WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
July 27, 2017

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

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

July 27, 2017
9:00 A.M. – 4:05 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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Tina Wooton
Chair

AGENDA
July 27, 2017

John Boyd, Psy.D.
Vice Chair

Approximate Times

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 May 25, 2017 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the May 25, 2017 MHSOAC meeting.

- Public Comment
- Vote

9:25 AM **Action**
2: Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations
Presenter: Filomena Yeroshek, Chief Counsel

The Commission will consider approval of the draft proposed amendments to the PEI and Innovation regulations submitted by the Regulations Subcommittee.

- Public Comment
- Vote

10:05 AM **Action**
3: 2017/18 MHSOAC Budget Approval
Presenter: Norma Pate, Deputy Director

The Commission will consider approving the MHSOAC 2017/18 MHSOAC Budget.

- Public Comment
- Vote

10:25 AM **Information**

4: 2017-18 MHSOAC Legislative Report

Presenter: Norma Pate, Deputy Director

The Commission will be provided with an update on legislation effecting the MHSOAC and the MHSA.

- Public Comment

10:40 AM **Information**

5: 7 Cups of Tea

Presenter: Glen Moriarty, Psy.D., Founder and CEO, 7cups.com

7 Cups of Tea (7cups.com) anonymously connects individuals seeking emotional support to active listeners via web and mobile applications. Dr. Moriarty will present the background, outcomes, and future potential for innovation for the 7 Cups of Tea model in California.

- Public Comment

11:20 AM **Action**

6: Senate Bill (SB) 82 Investment in Mental Health Wellness Act Request for Applications (RFA) principles

Presenters: Toby Ewing, Executive Director; Norma Pate Deputy Director; Tom Orrock, Triage Manager; Kristal Antonicelli, Project Lead

The Commission will consider adopting principles to guide the drafting of the SB 82 Triage grant RFA regarding statewide program evaluations, services for children and youth, and apportionment and sustainability options.

- Public comment
- Vote

11:50 PM **General Public Comment**

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

12:05 PM **Lunch Break**

1:30 PM **Information**

7: Farewell to Commissioner John Buck

The Commission will honor Commissioner John Buck.

- Public Comment

2:00 PM **Action**

8: Yolo County Innovation Plans

Presenters: Karen Larsen, Director, Yolo County Health and Human Services Agency (HHSA); Roberta Chambers, PsyD, Resource Development Associates; Sandra Sigrist, LCSW, Branch Director, Yolo County Adult and Aging Programs; Joan Beesley, MA, MHSA Program Manager

The Commission will consider approval of two Innovation Project Plans for Yolo County.

- Public Comment
- Vote

3:00 PM **Information**

9: Innovation Subcommittee Report-Out

Presenters: John Boyd, Psy.D., Commissioner; Itai Danovitch, M.D., Commissioner; Toby Ewing, Ph.D., Executive Director; Urmi Patel, Psy.D., Consulting Psychologist

The Commission will receive a status report from the Innovation Subcommittee.

- Public Comment

3:30 PM **Information**

10: Executive Director Report Out

Presenter: Toby Ewing, PhD, Executive Director, 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 May 25, 2017, Commission meeting; Evaluation Dashboard; Calendar of Commission activities; and Innovation Review Outline.

3:50 PM **General Public Comment**

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

4:05 PM **Adjourn**

AGENDA ITEM 1

Action

July 27, 2017 Commission Meeting

Approve May 25, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the May 25, 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: May 25, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve May 25, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the May 25, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
May 25, 2017

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

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, PsyD, Vice Chair
Lynne Ayers Ashbeck
Khatera Aslami-Tamplen
Sheriff Bill Brown
Kathleen Lynch
Gladys Mitchell
Larry Poaster, PhD
Richard Van Horn

Members Absent:

Reneeta Anthony
Senator Jim Beall
John Buck
Itai Danovitch, MD
David Gordon
Assemblymember Tony Thurmond

Staff Present:

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

[Note: Two 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 9:12 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton stated that the Mental Health Matters Day went well and included a number of speakers, including Richard Dreyfuss.

The second meeting of the Schools and Mental Health Subcommittee will be held on June 30th in Riverside.

The next MHSOAC meeting is scheduled for July 27th in Sacramento.

ACTION

1: Approve April 27, 2017, MHSOAC Meeting Minutes

Commissioner Poaster asked to change $682 million to $862 million on page 9.

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

The Commission approves the April 27, 2017, Meeting Minutes as revised.

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

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

The following Commissioners abstained: Commissioners Ashbeck and Brown.

ACTION

8: Request for Funding for Evaluation and Transparency Portal Projects

Presenters: Brian Sala, PhD, Deputy Director for Evaluation and Program; and Fred Molitor, PhD, Director of Research and Evaluation

Brian Sala, PhD, Deputy Director for Evaluation and Program, provided an overview, accompanied by a slide presentation, of the Full-Service Partnership (FSP) Classification Pilot and Transparency Data Portal and related IT support.

Fred Molitor, PhD, Director of Research and Evaluation, provided an overview, accompanied by a slide presentation, of the research findings, survey methodology, Phase 1 activities, and next steps of the Transition-Age Youth (TAY) Survey. He stated the research findings are represented in greater detail in the *Assessing Levels of Mental Health Need and Unmet Need Among TAY* report, which was included in the meeting packet.

Commissioner Questions and Discussion

Commissioner Ashbeck encouraged the Commission to work on the integration of physical and mental health, which is an area of concern with children's hospitals.

Vice Chair Boyd suggested adding homeless youth as a subpopulation. He asked if there are national partners who collect data and engage populations well, such as Mental Health America. He stated this is a good opportunity to find TAY to lead alongside the Commission from the beginning during the process of exploring the scope of the study and what engagement looks like, and defining what the care they receive looks like.

Chair Wooton noted an error on Slide 4. Deputy Director Sala agreed that it should be $520,000, or the sum of $275,000 and $245,000.

Public Comment

Poshi Walker, LGBTQ Program Director, Northern California Mental Health America (NorCal MHA), stated LGBTQ TAY are overrepresented among incarcerated and homeless youth and possibly military personnel. She asked if there is a plan to include the stakeholder contractors in this research. She stated the importance of including focus groups along with the online surveys.

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

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.*

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 Ashbeck, Aslami-Tamplen, Brown, Lynch, Mitchell, Poaster, and Van Horn.

ACTION

3: <u>Strategic Planning Contract</u>

Presenter: Toby Ewing, PhD, Executive Director

Toby Ewing, Executive Director, stated strategic planning discussions began with former Chair Victor Carrion but at the time he did not feel he had the capacity or experience as Executive Director with the Commission to do that well. He stated he is now ready to undertake this effort.

Commissioner Ashbeck suggested integrating innovative components in the strategic plan and securing a consultant who not only has experience in the transactional process of planning but can help the Commission look ahead.

Commissioner Mitchell encouraged a timely and efficient timeframe to complete the process. Executive Director Ewing stated he anticipates that the plan will be created by the end of the year; strategies will begin to be operationalized six months after that.

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

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.

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

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

INFORMATION

4: <u>Innovation Subcommittee Report Out</u>

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

Vice Chair Boyd stated the Innovation Subcommittee met yesterday and the meeting participants included at least 20 counties, other key stakeholders, and Commissioners. He stated he was pleasantly surprised at the amount of transparent discussion about the perceived and actual barriers at the Commission level and was left with a profound sense of collaboration and hope about the way that innovation could move forward in California. There was a deepened understanding about the challenges of this issue: that somehow innovation, which should be an inspiring, fun, and creative process, has at times been a difficult, challenging process that does not inspire and is not supported. There was recognition that the Innovation component of the MHSA not only fills gaps in services but is a huge learning opportunity that will inspire other individuals to transform the process at multiple levels.

Urmi Patel, PsyD, Consulting Psychologist, stated counties asked to engage with the Commission and staff earlier on in the process of the Innovation project plan development to gain their support and assistance in helping stakeholders understand that the Innovation project embraces learning and risk as an opportunity rather than a failure. Counties were interested in working with each other early on in the process and in how the Commission can link counties together during the developmental stages. Two or three

more Innovation Subcommittee meetings will be scheduled in the upcoming months to discuss strategies to improve the approval process to recommend to the full Commission.

Commissioner Questions and Discussion

Commissioner Ashbeck shared points from the Innovation Subcommittee meeting:

- Not all innovation is the same – there is a hierarchy pyramid of Innovations projects.
- Not all counties are the same – what is innovative to one county may not be to another county. What is innovative in one county needs to be judged within the context of that county.
- There is a shared language opportunity, such as eliminating the word “failure” from the language. Many opportunities have been lost because counties do not bring ideas forward for fear of failure.
- Create a way to share Innovation projects so counties can see what other counties have done and are currently doing.

Commissioner Van Horn stated the need to consider ways to encourage county directors to collaborate and share so it becomes easy to build joint Innovation projects.

Vice Chair Boyd stated this issue is in a state of transition to change the process to benefit everyone. He stated there needs to be grace on all sides in the coming months during this time of transformation. The Commission has the responsibility to effect statewide transformational change that changes the way that California, the nation, and other countries do this work. Innovation needs to be local but driven in the spirit of learning and true transformational change.

Vice Chair Boyd provided an update on the Innovation Summit. The Commission has contracted with IDEO, who has conducted deep dives into Monterey, Yolo, and Santa Clara counties. The California Behavioral Health Directors Association (CBHDA) recently released a survey developed by IDEO to solicit perspective ideas for Innovation projects on mental health across all counties. The Innovation Summit Day will be scheduled during the summer, but the Commission will set aside time during Commission meetings to provide broader updates to the public for individuals who cannot attend the Summit. A synthesis of all findings will be presented and posted on the Commission’s website.

Commissioner Mitchell stated the Commission is a common denominator between counties. She suggested creating a website where counties can post the Innovation projects they are working on so other counties can see what they are doing and collaborate early on. Dr. Patel stated she will meet with IT to discuss Commissioner Mitchell’s idea.

Vice Chair Boyd stated counties suggested presenting ideas to the Commission early on to get feedback as opposed to presenting at the end of the process.

Public Comment

Ms. Walker, stated the process within the counties may not include or represent some populations or knowledge base, especially in smaller and more conservative counties. She stated many county plans have been presented to the Commission that did not include LGBTQ or appropriately utilize peer support, but, by the time the plans are presented to the Commission, it is too late to make changes. She suggested that there be representation or that an initial draft be presented for public comment and feedback where voices can be represented that may not speak at the local level. She stated some counties may have difficulty promoting work with stigmatized populations. She stated the hope that those counties are supported in the Innovation projects.

Rusty Selix, California Council of Community Behavioral Health Agencies (CCCBHA), stated he helped put the Innovation component in the MHSA. He stated California is failing in its use of Innovation dollars. He reminded everyone that the founders of the MHSA thought Innovation was about Assembly Bill (AB) 34, wrap-around, what the next big transformational changes were going to be, and how to find them and make them go statewide. He stated that is not happening with the way Innovations projects are being done currently. He stated they envisioned that every Innovation project would have an evaluation that would be of benefit statewide and would tell everyone if this was something they all should be doing.

Mr. Selix suggested annually identifying three or four things to fund. These things may vary from year to year and may not use all of the Innovation funding. He suggested allowing counties to choose from a menu of those three or four things, such as schools and mental health or mental health and criminal justice. This would get multiple counties doing the same thing and benefitting from multi-county evaluation.

ACTION

5: <u>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, PhD, Director of Applied Research and Evaluation, Strategies Center

<u>Circle of Wellness: Mother, Child, and Family</u>

Stephanie Hess, MHSA Programs Coordinator, provided an overview of the proposed Circle of Wellness: Mother, Child, and Family Innovation project.

Kathleen Shenk, BS, Director of Strategies Center, provided an overview, accompanied by a slide presentation, of the primary problem, learning objectives, evaluation, and stakeholder engagement of the proposed Innovation project. She stated the Logic Model, which was included in the meeting packet, has more information about the short-, medium-, and long-term outcomes proposed for the project.

Commissioner Questions and Discussion

Commissioner Van Horn offered to share the contact information for UCLA, which is undertaking significant emotional wellbeing projects. Ms. Shenk welcomed the opportunity to speak with them.

Commissioner Ashbeck asked how this project adds value to the existing behavioral health work already being done in local clinics. Alex Abarca, LCSW, Director of Behavioral Health Services at Mariposa, Amador, Calaveras, Tuolumne (MACT) Health Board, Inc., stated Amador County has an integrated behavioral health system. This project represents the next step in greater integration in clinics that touch the patient early on.

Commissioner Aslami-Tamplen asked how many women are using hospital emergency rooms for mental health care. Ms. Shenk stated she would have to look at the public health data to get that figure. The difference in this project is that patients are immediately wrapped with support and mental health services as part of their care, rather than operating on a referral model.

Commissioner Van Horn asked why this project is funded by Amador County and not by all four counties that make up MACT. Ms. Hess stated Calaveras asked to collaborate with Amador but Amador did not think they could regionalize funds.

Commissioner Van Horn recommended that they regionalize the funding. Ms. Shenk stated the intent to use a comparison group from one of the other MACT clinics to administer the instruments at the same time to deepen evaluation and replicate the design, particularly in other rural areas.

Commissioner Ashbeck stated this is a great case study that highlights concerns brought up in yesterday's Innovation Subcommittee meeting.

Commissioner Van Horn commended the county on their work, which has needed to happen for a long time. He asked Ms. Hess to be a part of the Innovation Task Force. She agreed.

Commissioner Lynch asked if the county thought about how to reach the tribes. Mr. Abarca stated one of his partners is heavily involved in the tribal community. The MACT board is governed by tribe members and the advisory council has representatives from each tribe.

Commissioner Lynch asked if the OBs will be specially trained, and if there will be continual follow-up throughout pregnancy and postpartum. Mr. Abarca answered in the affirmative.

Commissioner Aslami-Tamplen stated the importance of including women who have experienced similar issues and support groups, such as for the loss of children at a young age. Ms. Shenk stated the Amador/Calaveras Perinatal Wellness Coalition has a multilevel project that addresses the more difficult issues. Mr. Abarca stated support groups naturally happen when patients are engaged and begin to know each other.

Vice Chair Boyd suggested looking at nearby IT startups to see if an online service would work with this project. He asked what other activities the full-time clinician will be asked

to do outside of caring for the 25 to 30 patients annually for this project. Ms. Shenk stated the time will be dedicated directly to the mental health emotional well-being visits. The child development assessment will be layered on through Baby Welcome Wagon and public health.

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

Ms. Hess provided an overview of the proposed Treatment Group for Teens/TAY with Co-Occurring Mental Health and Substance Use Disorders Innovation project.

Gregory Robinson, PhD, Director of Applied Research and Evaluation, Strategies Center, provided an overview, accompanied by a slide presentation, of the primary problem, learning objectives, evaluation, and stakeholder engagement of the proposed Innovation project. The Logic Model was included in the meeting packet.

Public Comment

Nina Machado, Executive Director, First5 Amador, spoke in support of both projects. She stated many Amador County pilot projects and systems changes have been adopted by larger counties.

Lori Halvorson, Nexus Youth and Family Services, spoke in support of the second project. She shared the story of a young person in Amador County who would have benefited from a project such as this.

Spencer Dutschke, Nexus Youth and Family Services, spoke in support of the second project. He shared the story of a young person in Amador County, which demonstrated the need for the proposed project.

Nadine Magana shared the story of her son, who would have benefited from the second proposed project.

Susan Gallagher, Executive Director, NorCal MHA, spoke in support of these projects but stated concern over the lack of peer support in them. Peer support needs to be at the core of the work. She suggested sharing the literature behind the evidence-based practices.

Heidi Strunk, California Association of Social Rehabilitation Agencies (CASRA), spoke in support of the projects. She stated the importance of incorporating peer support at the initial point of contact.

Sandra Marley, private advocate, suggested including a transportation component. She discussed traditional healers and normalizing mental health treatment. She suggested using alcoholics and narcotics anonymous, seeking out adult children of alcoholics, and perhaps finding a liaison person to bring in more of the community.

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

The MHSOAC approves Amador County'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) Years.

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

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

ACTION

6: <u>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; David Swanson, Senior Program Manager, Human Services Agencies

Kiran Sahota, MA, Mental Health Services Act (MHSA) Manager, introduced the members of the panel and stated the Board of Supervisors has approved the proposed project.

Hilary Carson, MSW, MHSA Administrator, Innovations, provided an overview, accompanied by a slide presentation, of the goal, purpose, and outcomes of the proposed Innovation project.

Dina Olivas, LCSW, Behavioral Health Manager, summarized the need in the county and how the proposed project will address that need.

Commissioner Questions

Commissioner Ashbeck asked how LVNs are associated with medication oversight. Ms. Olivas stated they work under the supervision of a psychiatrist.

Commissioner Aslami-Tamplen asked where the bilingual/bicultural staff are recruited from. Ms. Olivas stated they are recruited from a workforce investment internship program.

Vice Chair Boyd asked how the budget will be adjusted if they receive the requested Medi-Cal funding. Ms. Sahota stated the county will adjust their internal documents as the funding comes in.

Commissioner Mitchell referred to Slide 5, Measurable Outcomes, and asked what the expectation is for Number 2. Ms. Carson stated the county has yet to work on these questions. She stated initially it was meant to evaluate if connecting clients to mental health services within the first 15 days increases participation and retains involvement in the mental health services.

Public Comment
Ms. Marley asked about foster parent services, how the funding will be split up, and what will happen to counties that declare themselves sanctuary.

Commissioner Discussion

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

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

Commissioner Brown questioned the proposed Innovation project funding of $2,670,777 listed on Slide 6 and in the motion on Slide 8, when the total MHSA Innovation fund amount is $1,471,668. He stated the motion should be modified to $1,471,668. Deputy Director Sala stated staff gave the county three options for the budget presentation: (1) to ask for authorization of the full amount of the project with the expectation that they would draw down federal financial participation (FFP) and would not spend the whole amount authorized; (2) to ask for the amount the county anticipates to spend only from Innovation and, if they do not draw down as much FFP as they anticipate, to come back and ask for an amendment; and (3) an option in between recognizing the risk involved in the FFP drawdown. The county chose option 1.

Commissioner Brown asked if there is policy for this. Deputy Director Sala stated the Commission has seen a number of projects that have brought forth total project budgets that include funds from other sources. Typically, the county has only asked for the Innovation amount to be approved by the Commission. There is no stated policy position to direct staff on this and it has been a point of conversation with the counties.

Commissioner Van Horn stated the proposed amount should be the total budget amount because Medi-Cal and the Affordable Care Act (ACA) cannot be guaranteed in the next three years.

Commissioner Poaster asked if asking for all of the county's Innovation funding now will inhibit future Innovation projects. Ms. Sahota stated there are always Innovative projects in the queue; projects take some time to begin.

Executive Director Ewing asked, if the county draws down those Medi-Cal dollars, whether there is a commitment that the Medi-Cal dollars will staff for Innovation or whether they will go into the General Fund. Totally funding Innovation with Innovation dollars when there is access to federal dollars detracts from the goal of the Innovation pot, which is for those things that are not core services. If the funding drawn down is not put back into an Innovation pot, it will undermine the impact of Innovation as a policy goal of the MHSA.

Ms. Sahota stated the county was going to present the $1.4 million amount until last week, when it was changed to the full amount based on advice from staff.

Vice Chair Boyd suggested adding a friendly amendment that the Commission would approve the $2.6 million amount but that all spent funds from Innovation that were recaptured by Medi-Cal would return back into the Innovation category within the county.

Commissioner Mitchell stated she was struggling with the effectiveness of this project and was not convinced that it would benefit the foster care system.

Commissioner Poaster withdrew his motion.

Commissioner Brown stated the county's Board of Supervisors has approved a budget that has a certain amount coming from a Medi-Cal drawdown. He stated he would be more comfortable with approving the proposed project if the amount was modified and invited Ventura County to come back if they had a problem or issue.

Commissioner Van Horn asked how the county arrived at the $1,199,109 federal share. Ms. Sahota stated it was based on a projection of its fiscal team.

Action: Commissioner Brown made a motion that:

The MHSOAC approves Ventura County's Innovation Project with a modified amount, as follows:

Name: Children's Accelerated Access to Treatment and Services (CAATS)
Amount: $1,471,688
Project Length: Three (3) Years

Motion failed for lack of a second.

Executive Director Ewing stated some of the discussion is about the project and some is about the budget and how much funding comes out of the Innovation funding for that project. He suggested a motion that reflects a project with the full budget recognizing that it is the project that the Commission has authorized even if the funds are blended from a variety of sources. He suggested approving the project with the full budget of $2.6 million, with $1.4 million being MHSA funds. If the county needs more Innovation funds, that can be done on a later date.

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

The MHSOAC approves Ventura County's Innovation Project as presented, with the intent that the federal drawdown funding will return to the Innovation fund, as follows:

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

Motion failed 3 yes, 5 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Ashbeck, Aslami-Tamplen, and Van Horn.

The following Commissioners voted "No": Vice Chair Boyd and Commissioners Brown, Lynch, Mitchell, and Poaster.

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

The MHSOAC approves Ventura County's Innovation Project as presented, reflecting the budget that was presented, as follows:

Name: Children's Accelerated Access to Treatment and Services (CAATS)
Total Project Amount: $2,670,777 of which $1,471,668 is Innovation funds
Project Length: Three (3) Years

Motion carried 7 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

The following Commissioners voted "No": Commissioner Mitchell.

GENERAL PUBLIC COMMENT

Ms. Marley stated she learned government relations through an internship with the British Colombia Parliament. She stated opposition exists to bring out finer points to the government before bills are passed. She stated she attends Commission meetings as a Parliamentary-based opposition person and a Yankee.

Nicki King, PhD, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), discussed the recent RFP process for the stakeholder grants. She stated REMHDCO wrote a letter of disagreement with the way the process was handled and asked serious questions but has not heard back from the Commission.

Eva Nunez, consumer, shared her story of finding the Mental Health Steering Committee, which helped build her confidence, education, and knowledge of what mental health is and beyond.

ACTION

7: <u>San Diego County Innovation Plans</u>

Presenters: Alfredo Aguirre, LCSW, Director of Behavioral Health Services of San Diego County; Piedad Garcia, EdD, 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; and Cecily Thornton-Stearns, Behavioral Health Program Coordinator

Alfredo Aguirre, LCSW, Director of Behavioral Health Services of San Diego County, introduced the members of the panel. He provided an overview, accompanied by a slide presentation, of the demographics and community program planning process of San Diego County.

Roaming Outpatient Access Mobile (ROAM) Services

Piedad Garcia, EdD, Deputy Director for the County of San Diego, Adult and Older Adult BHS, provided an overview, accompanied by a slide presentation, of the identified problems, program description, Innovation components, and objectives of San Diego County's first proposed Innovation project.

Commissioner Questions

Commissioner Brown asked if the county has discussed this project with the tribes and if the tribes will allow the mobile teams onto their reservations. Dr. Garcia stated there do not appear to be any issues or concerns with the mobile units or allowing them onto the reservations. The best location for the mobile units to park on the reservations is still to be determined.

Commissioner Ashbeck asked if the county will make midcourse corrections should the project prove unsuccessful. Dr. Garcia stated the evaluation component will begin to signal its success within the first year and the county will remain flexible to make adjustments as needed.

Commissioner Brown asked if there have been discussions about making the mobile units as innocuous as possible by partnering with another program that can be provided in the same vehicle or a generic type of delivery that would not further stigmatize. Dr. Garcia stated the units will not include language that would further stigmatize the access to mental services by these communities. She stated the communities already have mobile health clinics and libraries that are more like vans.

Vice Chair Boyd suggested sending cultural brokers into the communities ahead of this project to begin to build trust.

Recuperative Services Treatment (ReST) Housing

Dr. Garcia provided an overview, accompanied by a slide presentation, of the identified problems, program description, Innovation components, and objectives of San Diego County's second proposed Innovation project.

Commissioner Questions

Commissioner Ashbeck stated this project seems more like a gap in services than something innovative. She asked what is innovative to the county of San Diego. Dr. Garcia stated the innovative part is the youth, who are unconnected to mental health services and housing other than jail, acute care hospital, and emergency departments. The county has other programs that have been unsuccessful in encouraging youth to come to mental health clinics. This project is like a net for youth to ensure they have the resources and knowledge of how to transition back into the community.

Dr. Aguirre stated the county is proposing to put pieces together to demonstrate an innovative approach to address a need in the community; the project taken as a whole is what is innovative.

Commissioner Ashbeck asked where the project will be located. Dr. Garcia stated it will be a 12- to 15-unit housing property. Cecily Thornton-Stearns, Behavioral Health Program

Coordinator, San Diego County, stated there is emergency housing for TAY through a faith partner that secures homes in neighborhoods.

Medication Clinic

Jeffrey Rowe, M.D., Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services, provided an overview, accompanied by a slide presentation, of the identified problems, program description, innovation components, and objectives of San Diego County's third proposed Innovation project. He stated he reduced Slide 29 into a handout provided at the meeting to demonstrate how this project is different from other consultation programs.

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, summarized the project budget slide.

Commissioner Questions

Vice Chair Boyd asked why the county chose to add onto a piece of a system rather than do something that brings communitywide transformational change. Dr. Rowe stated the project presented today is community-informed, addresses a need, and provides an innovative approach that does not exist.

Commissioner Ashbeck asked how this project is integrated. Dr. Rowe stated a child who has an IEP or psychotherapy or may be on multiple medications can be serviced by the proposed clinic. This project addresses children with chronic mental health issues for as long as they need it.

Commissioner Van Horn stated he does not understand why the eight outpatient clinics in San Diego County that see children have to transfer them off after an average of only 13 visits. Dr. Aguirre stated that research done in private and public organizations on outpatient care for children's mental health indicates that the average length of care is 8 to 15 visits. The problem this project will address is to help the children who need more than that. This project is an innovative approach to address a need that is not being met.

Commissioner Van Horn asked if the county has contacted legacy outpatient children's clinics. Ms. Koenig stated they have not.

Commissioner Mitchell stated she does not see how this project is innovative. She asked how to help make counties more innovative. Dr. Aguirre stated the county seeks help from the communities they serve.

Commissioner Aslami-Tamplen asked if there is a plan to help children come off medications. Dr. Rowe stated better continuity of care increases the psychiatrists' willingness to take children off medication.

Public Comment

Ms. Marley asked if cultural brokers will go through county personnel or a subcontractor. She suggested reaching out to AANA, NAMI, and others that have a long-term recovery process to reduce stigma. She stated she did not see how certain things can be done in 90 days. She asked who will prescribe the medications.

Matthew Gallagher, Law Clerk, Young Minds Advocacy, stated concern about the ReST project and questioned what was innovative about it. He asked what follow-up or procedural safeguards will ensure the youth stay connected after the 90 days and how the county will ensure the services provided to the youth are culturally competent. He agreed with Commissioner Van Horn's comment about the importance of continuity with the psychiatrist and that 13 visits is not enough.

Commissioner Discussion

Vice Chair Boyd asked about the status of the housing funds and why this project was not funded with the MHSA housing funds. Dr. Garcia stated the county partners with the Housing and Community Development for tenant-based subsidies and San Diego Commission for food service, treatment, and housing. She stated the county set aside $10 million for a 69-unit housing development.

Commissioner Poaster stated these proposals met the requirements under the statute and regulations to increase service and address community needs. The Commission is in a transition period and Innovation has many definitions.

Commissioner Mitchell stated she will support the proposals but cautioned that counties must do better by the people they serve.

Commissioner Ashbeck suggested asking the Board of Supervisors to allow these proposals, such as the mobile unit, to be piloted in a small region. She stated a resource fair and videos are not state-of-the-art for the medication clinic. Dr. Aguirre stated these populations have not seen videos about learning disabilities, do not know what psychotropic medications are used for, and do not know what the common side effects are; they have no access to this information.

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

The MHSOAC approves San Diego's Innovation Project, as follows:

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

Motion carried 5 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Ashbeck, Aslami-Tamplen, Mitchell, Poaster and Van Horn.

The following Commissioner voted "No": Vice Chair Boyd.

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

The MHSOAC approves San Diego's Innovation Project, as follows:

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

Motion carried 5 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Ashbeck, Aslami-Tamplen, Mitchell, Poaster, and Van Horn.

The following Commissioner voted "No": Vice Chair Boyd.

Action: Commissioner Poaster made a motion, seconded by Commissioner Mitchell, that:

The MHSOAC approves San Diego's Innovation Project, as follows:

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

Motion carried 5 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Vice Chair Boyd and Commissioners Ashbeck, Aslami-Tamplen, Mitchell, and Poaster.

The following Commissioners voted "No": Commissioner Van Horn.

INFORMATION

2: <u>Governor's May Budget Revise Update</u>

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

Jessica Sankus, Department of Finance (DOF), summarized the updated revenues of the Mental Health Services Fund as of the Governor's May Budget Revise. She stated a notification letter was sent to the Legislature from the DOF concerning three items that were appropriated with the 2016 Budget Act, which were subject to the availability of funds within the five percent state administrative cap: $11 million was disbursed to the California Health Facilities Financing Authority for children's crisis grant services, $4 million was disbursed to the Department of Health Care Services (DHCS) for suicide hotlines, and $3 million was disbursed to the MHSOAC for children's crisis services.

Ms. Sankus highlighted the chart she distributed at the meeting, titled "Mental Health Services Fund Administrative Cap – 2017-18 May Revision Revenue Updates." She stated the chart is updated three times per year and shows the five percent state administrative funds. She directed the Commissioners' attention to the updated revenue estimate and expenditures from the five percent cap on those revenues for state operations.

Kris Cook, DOF, stated the chart is difficult to follow and the numbers are not intuitive but the big takeaway is the two red numbers in the 2016-17 column, which reflect the amount of funds that were obligated.

INFORMATION

9: Executive Director Report Out

Presenter: Toby Ewing, PhD, Executive Director

Executive Director Ewing presented his report as follows:

Personnel

Edward Molloy will join the Commission in the 2nd week of June as a summer intern.

Legislative Updates

The 3 bills sponsored by the Commission, fact-finding tours, fellowship, and wage data from the Employment Development Department, have moved out of the Assembly and are in the Senate. Staff is providing technical assistance on the school mental health bills.

Project Updates

Criminal Justice and Mental Health

A draft report will be presented to the subcommittee during the summer.

Regulation Implementation

The next subcommittee meeting will be on June 1st. The subcommittee is working with small counties to better understand their needs.

Fiscal Reversion

The report is being edited and will be posted online.

Schools and Mental Health

The next subcommittee meeting is on June 30th in Riverside.

Stakeholder Contracts

Staff will work with the Chair and Vice Chair to respond to letters received regarding the stakeholder contracts and Commissioners will receive copies of the letters.

New Topics

Staff continues to work on White Papers for topics as requested by the Commission. Collective impact will be addressed through strategic planning.

The Assembly passed a proposed budget to ask the Commission to do a project on suicide prevention. They are leaning in the direction of asking the MHSOAC to write a suicide prevention strategic plan for the state of California and have tentatively authorized an additional $100,000 for the Commission to hire contractors to begin this work.

Innovation Subcommittee

The subcommittee met yesterday. It has surveyed the counties and hopes to send surveys out to Commissioners and others within the next few weeks to gather input on Innovation.

GENERAL PUBLIC COMMENT

Suzanne Edises, mental health advocate, encouraged pushing the envelope in innovations to get at prevention and early intervention.

ADJOURN

There being no further business, the meeting was adjourned at 4:03 p.m.

AGENDA ITEM 2

Action Item

July 27, 2017 Commission Meeting

Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations

Summary
The Commission will consider approval of draft proposed amendments to the PEI and Innovation regulations submitted by the Regulations Implementation Subcommittee (Subcommittee).

Background
In late 2015 the Mental Health Services Oversight and Accountability Commission (OAC or Commission) formed a Subcommittee consisting of Commissioner Poaster as chair, and Commissioners Aslami-Tamplen and Van Horn to work with the County Behavioral Health Directors Association (CBHDA), counties, consumers, family members, community mental health providers, and other stakeholders to address concerns regarding the implementation of the recently issued PEI and Innovation regulations.

The Subcommittee held six public meetings throughout the State to better understand the challenges faced by counties and providers in implementing the regulations. The OAC, at its October 2016 meeting, adopted the proposed report submitted by the Subcommittee, *Finding Solutions, Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act* ("*Finding Solutions* report"). In its report, the Commission made five key recommendations, including amending the regulations. In January 2017 the Commission endorsed high-level strategies to operationalize these recommendations.

The Subcommittee met subsequently on March 7, April 12, and June 1, 2017 to discuss and obtain input on specific proposed amendments to the PEI and Innovation regulations in accordance with the recommendations in the *Finding Solutions* report.

The draft proposed amendments reviewed by the Subcommittee do the following:

- Specify for both PEI programs and Innovation projects that serve children and youth under 18 years of age that demographic information is to be collected and reported only to the extent permitted by federal and state privacy and education laws.

- Specify for both PEI programs and Innovation projects that counties are not required to collect demographic information from a minor younger than 12 years of age.
- Clarify that each county's referral reporting responsibility extends only to referrals made to other county programs, whether such programs are operated by counties or providers.
- Provide a definition of "referral" for purpose of data collection and reporting.
- Authorize the counties to provide the required Access and Linkage to Treatment Program through another Mental Health Services Act funding stream, such as Community Services and Supports.
- Provide data collection and reporting flexibility to very small counties due to their unique challenges.
- Change the due dates of the reports to better align with other county fiscal and programmatic reports that a county is already required to submit.

Subcommittee Recommendation
At the June 1, 2017 meeting the Subcommittee voted to submit to the Commission for consideration the draft proposed amendments that are before the Commission at the July 27, 2017 meeting. The Subcommittee endorsed all of the proposed amendments except it did not decide one issue: whether the exemption allowing a county to combine and/or integrate all of the required PEI standalone programs should apply to counties with a population under 100,000 or under 50,000. The Subcommittee agreed that the regulations should provide this flexibly, however, despite extensive discussion, the Subcommittee was divided on whether the population threshold should be under 50,000 or under 100,000.

Next Steps:
The following is a list of some of the next steps in the process to amend the regulations:

- Upon Commission adoption of the draft proposed amendments, staff will prepare and finalize the Initial Statement of Reasons and all other forms and documents necessary for submittal to the Office of Administrative Law (OAL).
- If the Commission adopts the proposed amendments at the July 27th meeting, it is anticipated that the Notice of Proposed Rulemaking would be submitted to the OAL for publication on August 11, 2017 which will start the 45-day public comment period.
- August 11, 2017 through September 28, 2017 is the official regulatory 45-day public comment period.
- The Commission will hold a public hearing on the proposed amendments at its September 28, 2017 meeting.

- At the October 26 or November 16, 2017 meeting the Commission will decide whether to make changes to the proposed amendments in response to the public comments received. Changes to the regulations may trigger an additional 15-day or 45-day public comment period, depending on the nature of the changes.
- If no additional changes are made, the Rulemaking Record is closed and submitted in December 2017 or January 2018 to the OAL for review and approval.
- The OAL has 30 business days to make a determination.
- Depending upon OAL's approval the amendments will go into effect April 1 or July 1, 2018.

Presenter: Filomena Yeroshek, Chief Counsel

Enclosures: (1) Draft Proposed Amendments to the Prevention and Early Intervention Regulations; (2) Initial Statement of Reasons for the Amendments to the Prevention and Early Intervention Regulations; (3) Draft Proposed Amendments to the Innovative Project Regulations; and (4) Initial Statement of Reasons for the Amendments to the Innovative Project Regulations

Handouts: PowerPoint presentation will be available at the meeting.

Proposed Motion

1. The Commission approves the Draft Proposed Amendments to the Innovative Project Regulations as presented.

2. The Commission approves the Draft Proposed Amendments to the Prevention and Early Intervention Regulations as presented.

3. The Executive Director is authorized to approve any necessary non-substantive editorial changes to the proposed amendments to both the Innovative Project and Prevention and Early Intervention regulations and to submit the approved proposed amendments with the supporting documentation required by law to the Office of Administrative Law and proceed as required by the Administrative Procedures Act.

Mental Health Services Oversight and Accountability Commission Meeting
July 27, 2017

In October 2016 the Mental Health Services Oversight and Accountability (MHSOAC) adopted the report, *Finding Solutions, Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act.* To implement some of the recommendation in the report, the Subcommittee on Prevention and Early Intervention and Innovation Regulations at its June 1, 2017 meeting considered proposed amendments to the Prevention and Early Intervention regulations to be submitted to the MHSOAC. The proposed amendments that were approved by the Subcommittee at the June 1, 2017 meeting are set forth below and are shown in underlined text (new language) and strikethrough text (deleted language). However, the Subcommittee did not take a position on the text that is highlighted in yellow on pages 8, 12, and 19 as to whether regulatory requirements identified in the language should apply to counties with a population under 50,000 or under 100,000.

Article 5. Reporting Requirements

Amend Section 3560 as follows:

Section 3560. Prevention and Early Intervention ~~Reports~~ Reporting Requirements.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following ~~Prevention and Early Intervention reports~~:
  (1) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ report as specified in Section 3560.010.
  (2) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report as specified in Section 3560.020.

Amend Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.
  (1) The first Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2017 as part of the Annual Update or Three-Year Program and Expenditure Plan ~~and no later than December 30th every year thereafter except for years in which the Three-Year Program and Evaluation Report is due~~. Each Annual Prevention and Early Intervention Report thereafter is due to the Mental Health Services Oversight and Accountability Commission as part of the Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisor approval but no later than June 30 of the current fiscal year whichever occurs first.
  (2) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report shall report on the required data for the fiscal year prior to the due date. For example, the Report that is due no

later than June 30, 2020 is to report the required data from fiscal year 2018-19 (i.e. July 1, 2018 through June 30, 2019).

(3) The County shall exclude from the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (3) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains all of the information including the information that was excluded pursuant to subdivision (3). This supplemental report shall be marked "confidential."
2. A supplement to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains the information that was excluded pursuant to subdivision (3). This supplement to the report shall be marked "confidential."

(b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:

(1) For each Prevention Program and each Early Intervention Program list:

(A) The Program name.

(B) Unduplicated numbers of individuals served in the preceding fiscal year

1. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
2. If a Program served families the County shall report the number of individual family members served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness Program or Strategy within a Program, the County shall report:

(A) The Program name

(B) The number of potential responders

(C) The setting(s) in which the potential responders were engaged

1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.

(D) The type(s) of potential responders engaged in each setting (e.g. nurses, ~~principles~~ principals, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:
  (A) The Program name
  (B) Number of individuals with serious mental illness referred to treatment <u>that is provided, funded, administered, or overseen by county mental health</u>, and the kind of treatment to which the individual was referred.
  (C) Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.
  (D) Average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.
  (E) Average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.
  <u>(F) "Referral" as used in this subdivision means the process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.</u>

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:
  (A) The program name
  (B) Identify the specific underserved populations for whom the County intended to increase timely access to services.
  (C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.
  (D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.
  (E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.
  (F) Description of ways the County encouraged access to services and follow-through on referrals.
  <u>(G) "Referral" as used in this subdivision means the process by which a member of an underserved population is given a recommendation in writing to one or more specific service provider for a Prevention Program, an Early Intervention Program and/or a program providing treatment beyond early onset. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.</u>

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:
  (A) The following age groups:
    1. 0-15 (children/youth)
    2. 16-25 (transition age youth)

3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:
1. Hispanic or Latino as follows
   a. Caribbean
   b. Central American
   c. Mexican/Mexican-American/Chicano
   d. Puerto Rican
   e. South American
   f. Other
   g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation

7. Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness

1. Yes, report the number that apply in each domain of disability(ies)
    a. Communication domain separately by each of the following
        (i) Difficulty seeing,
        (ii) Difficulty hearing, or having speech understood
        (iii) Other (specify)
    b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
    c. Physical/mobility domain
    d. Chronic health condition (including, but not limited to, chronic pain)
    e. Other (specify)
2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,

1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender

1. Assigned sex at birth:
    a. Male
    b. Female
    c. Number of respondents who declined to answer the question
2. Current gender identity:
    a. Male
    b. Female
    c. Transgender
    d. Genderqueer
    e. Questioning or unsure of gender identity
    f. Another gender identity
    g. Number of respondents who declined to answer the question

(6) Any other data the County considers relevant, for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more Prevention and Early Intervention funded services.

(7) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, the County may report available numbers of individuals reached, including demographic

breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(8) For all programs and Strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

(c) For a program serving children or youth younger than 18 years of age, the demographic information required under subdivision (b)(5) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(d) A county is not required to collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age.

(e) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may report the demographic information required under subdivision (b)(5) of this section for the County's entire Prevention and Early Intervention Component instead of by each Program or Strategy.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3560.020 as follows:

Section 3560.020. Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report.

(a) The County shall submit the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of the Three-Year Program and Expenditure Plan or Annual Update. The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report answers questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

(1) The first Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission on or before ~~December 30, 2018~~ June 30, 2019 as part of the Annual Update or Three-Year Program and Expenditure Plan for fiscal years 2017/18 through 2019/20. The first Three-Year Prevention and Early Intervention Evaluation Report shall report the required data from fiscal year 2017-2018 and from the prior fiscal year if available. Each subsequent ~~The~~ Three-Year Program and Evaluation Report shall be due no later than ~~December 30th~~ June 30th every three years thereafter and shall report on the evaluation(s) for the three fiscal years prior to the due date.

(2) The County shall exclude from the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security

regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (2) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains all of the information including the information that was excluded pursuant to subdivision (2). This supplemental report shall be marked "confidential."
2. A supplement to the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains the information that was excluded pursuant to subdivision (2). This supplement to the report shall be marked "confidential."

(b) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall describe the evaluation of each Prevention and Early Intervention Component Program and two Strategies: Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations. The Report shall include the following:

(1) The name of each Program for which the county is reporting

(2) The outcomes and indicators selected for each Prevention, Early Intervention, Stigma and Discrimination Reduction, or Suicide Prevention Program

(3) The approaches used to select the outcomes and indicators, collect data, and determine results for the evaluation of each Program and the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(4) How often the data were collected for the evaluation of each Program and for the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(c) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall provide results and analysis of results for all required evaluations set forth in Section 3750 for the three fiscal years prior to the due date.

(d) The County may also include in the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report any additional evaluation data on selected outcomes and indicators, including evaluation results related to the impact of Prevention and Early Intervention Component Programs on mental health and related systems.

(e) The County shall include the same information for the previous fiscal year that otherwise would be reported in the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report in response to requirements specified in 3560.010(b).

(f) The County may report any other available evaluation results in the County's Annual Updates.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Article 7. Prevention and Early Intervention

Amend Section 3705 as follows:

Section 3705. Prevention and Early Intervention Component General Requirements.

(a) The County shall include in its Prevention and Early Intervention Component:
  (1) At least one Early Intervention Program as defined in Section 3710.
  (2) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in Section 3715.
  (3) At least one Prevention Program as defined in Section 3720
    (A) Small counties may opt out of the requirement to have at least one Prevention Program if:
      1. The Small County obtains a ~~declaration~~ resolution from the Board of Supervisors that the County cannot meet this requirement.
    (B) A Small County that opts out of the requirement in (a)(3) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.
  (4) At least one Access and Linkage to Treatment Program as defined in Section 3726
    (A) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may opt out of the requirement to have at least one Access and Linkage to Treatment Program if:
      1. The County obtains a resolution from the Board of Supervisors that the County cannot meet this requirement.
    (B) A County that opts out of the requirement in (a)(4) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.
  (5) At least one Stigma and Discrimination Reduction Program as defined in Section 3725
  (6) The Strategies defined in Section 3735.
(b) The County may include in its Prevention and Early Intervention Component:
  (1) One or more Suicide Prevention Programs as defined in Section 3730.
(c) A County with a population under 50,000, according to the most recent projection by the California State Department of Finance, may satisfy the requirements in subdivisions (a)(1) through (a)(5) of this Section by combining and/or integrating the Early Intervention Program, the Outreach for Increasing Recognition of Early Signs of Mental Illness Program, the Prevention Program, the Access and Linkage to Treatment Program, and the Stigma and Discrimination Reduction Program.
  (1) A county that utilizes this provision shall not also opt-out of the requirement to have at least one Prevention Program under subdivision (a)(3) or of the requirement to have at least one Access and Linkage to Treatment Program under subdivision (a)(4).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3726 as follows:

Section 3726. Access and Linkage to Treatment Program.

(a) The County shall offer at least one Access and Linkage to Treatment Program as defined in this section.
(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~, including, but not limited to, care~~ provided, funded, administered, or overseen by county mental health programs.
    (1) Examples of Access and Linkage to Treatment Programs, include but are not limited to, Programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response.
(c) In addition to offering the required Access and Linkage to Treatment Program, the County is also required to offer Access and Linkage to Treatment as a Strategy within all Prevention and Early Intervention Programs.
(d) The County shall include all of the Strategies in each Access and Linkage to Treatment Program as referenced in Section 3735.
(e) An Access and Linkage to Treatment Program may be provided through other Mental Health Services Act components as long as they meet all of the requirements in this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3 and 5840, Welfare and Institutions Code.

Amend Section 3735 as follows:
Section 3735. Prevention and Early Intervention Strategies.

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:
    (1) Be designed and implemented to help create Access and Linkage to Treatment.
        (A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~, including, but not limited to, care~~ provided, funded, administered, or overseen by county mental health programs.
    (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.
        (A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

(B) Services shall be provide in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.

(C) In addition to offering the required Improve Timely Access to Services for Underserved Populations Strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a Program.

(3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory

(A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

(B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3750 as follows:

Section 3750. Prevention and Early Intervention Component Evaluation.

(a) For each Early Intervention Program the County shall evaluate the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(b) For each Prevention Program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(c) For each Early Intervention and each Prevention Program that the County designates as intended to reduce any of the other Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness, the

County shall select, define, and measure appropriate indicators that the County selects that are applicable to the Program.

(d) For each Stigma and Discrimination Reduction Program referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:
  (1) Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program.
  (2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.

(e) If the County chooses to offer a Suicide Prevention Program referenced in Section 3730, the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program.

(f) For each Strategy or Program to provide Access and Linkage to Treatment the County shall track:
  (1) Number of referrals as defined in subdivision (b)(3)(F) of section 3560.010 to treatment, and kind of treatment to which person was referred.
  (2) Number of persons who followed through on the referral as defined in subdivision (b)(3)(F) of section 3560.010 and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.
    (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
  (3) Duration of untreated mental illness.
    (A) Duration of untreated mental illness shall be measured for persons who are referred as defined in subdivision (b)(3)(F) of section 3560.010 to treatment and who have not previously received treatment as follows:
      1. The time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment, defined as participating at least once in treatment to which the person was referred.
    (B) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
  (4) The interval between the referral as defined in subdivision (b)(3)(F) of section 3560.010 and engagement in treatment, defined as participating at least once in the treatment to which referred
    (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(g) For each Strategy or Program to Improve Timely Access to Services for Underserved Populations the County shall measure:

(1) Number of referrals as defined in subdivision (b)(4)(G) of section 3560.010 of members of underserved populations to a Prevention Program, an Early Intervention Program, and/or treatment beyond early onset.

(2) Number of persons who followed through on the referral as defined in subdivision (b)(4)(G) of section 3560.010 and engaged in services, defined as the number of individuals who participated at least once in the Program to which the person was referred.

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(3) Timeliness of care.

(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval between referral as defined in subdivision (b)(4)(G) of section 3560.010 and engagement in services, defined as participating at least once in the service to which referred.

(h) The County shall design the evaluations to be culturally competent and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.

(i) In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of Programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

(j) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, is exempt from the evaluation requirements in this section for one year from the effective date of this section.

(k) A County with a population under 50,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 may satisfy the requirements of subdivisions (a) through (g) of this section by selecting, defining, and measuring appropriate indicators that the County selects to evaluate the negative outcomes referenced in Welfare and Institutions Code section 5840, subdivision (d), identified in the County's Three-year Program and Expenditure Plan and/or Annual Update pursuant to subdivision (o)(2) of section 3755.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3755 as follows:

Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.

(a) The requirements set forth in this section shall apply to the Annual Update due for the fiscal year 2016-17 and each Annual Update and/or Three-Year Program and Expenditure Plan thereafter.

(b) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:

(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component.

(2) A description of the County's plan to involve community stakeholders meaningfully in all phases of the Prevention and Early Intervention Component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

(3) A brief description, with specific examples of how each Program and/or Strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all applicable Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.

(c) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Early Intervention Program as defined in Section 3710 including, but not limited to:

(1) The Program name

(2) Identification of the target population for the specific Program including:

(A) Demographics relevant to the intended target population for the specific Program, including, but not limited to, age, race/ethnicity, gender or gender identity, primary language used, military status, and sexual orientation.

(B) The mental illness or illnesses for which there is early onset.

(C) Brief description of how each participant's early onset of a potentially serious mental illness will be determined.

(3) Identification of the type(s) of problem(s) and need(s) for which the Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with early onset of potentially serious mental illness.

(4) The Mental Health Services Act negative outcomes as a consequence of untreated mental illness referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, as defined in Section 3750, subdivision (a).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (a).

(B) For any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness, as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Early Intervention Program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(d) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Prevention Program including but not limited to the following information:

(1) The Program name

(2) Identification of the target population for the specific Program, including:

(A) Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness, i.e. the condition, experience, or behavior associated with greater than average risk.

(B) How the risk of a potentially serious mental illness will be defined and determined, i.e. what criteria and process the County will use to establish that the intended beneficiaries of the Program have a greater than average risk of developing a potentially severe mental illness.

(C) Demographics relevant to the intended target population for the specific Program including but not limited to age, race/ethnicity, gender or gender identity, sexual orientation, primary language used, and military status.

(3) Specify the type of problem(s) and need(s) for which the Prevention Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in

Welfare and Institutions Code Section 5840, subdivision (d) for individuals with greater than average risk of potentially serious mental illness.

(4) Specify any Mental Health Services Act negative outcomes as a consequence of untreated mental illness as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including reduction of prolonged suffering, as defined in Section 3750, subdivision (b).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).

(B) If the County intends the Program to reduce any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Prevention Program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(e) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Outreach for Increasing Recognition of Early Signs of Mental Illness Program and for any Strategy within a Program, including, but not limited to:

(1) The Program name

(2) Identify the types and settings of potential responders the Program intends to reach.

(A) Describe briefly the potential responders' setting(s), as referenced in Section 3750, subdivisions (d)(3)(A), and the opportunity the potential responders will have to identify diverse individuals with signs and symptoms of potentially serious mental illness.

(3) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

(f) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Stigma and Discrimination Reduction Program, including, but not limited to:

(1) The Program name

(2) Identify whom the Program intends to influence.

(3) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services, consistent with requirements in Section 3750, subdivision (e), including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard, to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(g) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Suicide Prevention Program including, but not limited to:

(1) The Program name

(2) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.

(3) Indicate how the County will measure changes in attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the

County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(h) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Access and Linkage to Treatment Program and Strategy within each Program including, but not limited to:

(1) Program name

(2) An explanation of how the Program and Strategy within each Program will create Access and Linkage to Treatment for individuals with serious mental illness as referenced in Section 3735, subdivision (a)(1)

(3) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program.

(4) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.

(5) Explain how the Program will follow up with the referral to support engagement in treatment.

(6) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (f) and if so, specify what outcome(s) and how will it be measured, including timeframes for measurement.

(i) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:

(1) Program name

(2) An explanation of how the Program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a)(2)

(3) For each Program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the County intends to locate the Program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population.

(4) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcome(s) and how will it be measured, including timeframes for measurement.

(j) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:

(1) The Program name

(2) An explanation of how the Program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, including a description of the specific Strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.

(k) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs the following information for the fiscal year after the plan is submitted.

(1) Estimated number of children, adults, and seniors to be served in each Prevention Program and each Early Intervention Program.

(2) The County may also include estimates of the number of individuals who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Access and Linkage to Treatment Program, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

(l) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include projected expenditures for each Program funded with Prevention and Early Intervention funds by fiscal year

(1) Projected expenditures by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(2) The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, an Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations and shall estimate expected expenditures for each Program. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(A) The County shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Component.

(m) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include the previous fiscal years' unexpended Prevention and Early Intervention funds and the amount of those funds that will be used to pay for the Programs listed in the Annual Update and/or Three-year Program and Expenditure Plan.

(n) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include an estimate of the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(o) A County with a population under 50,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 shall include in the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update the following information:

(1) Description of how it has combined and/or integrated the programs.

(2) Identification of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) the combined and/or integrated program is intended to reduce.

(3) Description of how the combined and/or integrated program is likely to reduce the outcomes identified in part (2) above.

(4) Identification of the indicators that the County will use to measure the intended outcomes identified in part (2) above.

(5) Explanation of how the combined and/or integrated program will be implemented to help Improve Access to Services for Underserved Population, as required in Section 3735, subdivision (a)(2).

(6) Explanation of how the combined and/or integrated program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, as required in Section 3735, subdivision (a)(3).

(7) Estimated number of children, adults, and seniors to be served in the combined and/or integrated program.

(8) List of the projected expenditures for the combined and/or integrated program funded with Prevention and Early Intervention funds by fiscal year and by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(9) Estimated amount of Prevention and Early Intervention funds budgeted for Administration of the Prevention and Early Intervention Component.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5847, and 5848 Welfare and Institutions Code.

Mental Health Services Oversight and Accountability Commission

Initial Statement of Reasons
Prevention and Early Intervention Programs
AMENDMENTS TO PREVENTION AND EARLY INTERVENTION REGULATIONS

SUBJECT MATTER OF PROPOSED REGULATIONS:

Prevention and Early Intervention (PEI) Programs of the Mental Health Services Act.

SECTIONS AFFECTED: 3560, 3560.010, 3560.020, 3705, 3726, 3735, 3750 and 3755

PROBLEM STATEMENT

California voters approved Proposition 63 in the November 2004 General Election. Proposition 63 became effective on January 1, 2005 as the Mental Health Services Act (MHSA). The MHSA intends to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness through imposition of a 1% tax on personal income in excess of $1M.

The MHSA established the Mental Health Oversight and Accountability Commission (MHSOAC) to oversee the community mental health system and the new programs established by the MHSA, including Prevention and Early Intervention Programs.

In 2013 the MHSOAC was charged, as the result of Assembly Bill 82, (Committee on Budget, Chapter 23, Statutes of 2013) to develop and promulgate regulations for the Prevention and Early Intervention (PEI) component of the MHSA. Those regulations were completed and went into effect October 6, 2015. In the months following the October 6, 2015 promulgation of the Prevention and Early Intervention regulations, representatives of California's county behavioral health agencies raised multiple concerns about their ability to comply with some of the new regulations. During 2016 the MHSOAC conducted a series of public meetings throughout the state to gather information on the specific implementation challenges and strategies to address those challenges. The proposed amendments to the regulations are a result of this yearlong public input process (hereinafter "statewide implementation meetings").

PURPOSE AND REASONABLE NECESSITY OF AMENDMENTS TO REGULATION

The amendments are reasonably necessary to address the challenges and barriers to implementing the regulations that were identified in the statewide implementation meetings.

BENEFITS

This regulatory proposal, amending sections of the Prevention and Early Interventions regulations, first promulgated in 2016, helps to ensure that California's county behavioral health agencies, the entities responsible to comply with the regulations issued in 2016, are better able to comply with those regulatory requirements. The initial regulations provided for the first time statewide consistency and conformity in the administration and reporting of program data and evaluation that enables the

MHSOAC to conduct more effective oversight and evaluation of the programs. Better compliance with the regulations ultimately will help to increase the quality of mental health services programs.

STATEMENT FOR EACH PROPOSED ADOPTION, AMENDMENT, OR REPEAL

The following sections set forth the specific purpose of each amended regulation and the rationale for the MHSOAC's determination that each amendment is reasonably necessary to carry out the purpose for which it was proposed.

Section 3560(a) and (a)(1)-(2); Section 3650.010(a) and (a)(1)-(3); and Section 3650.020(a), (a)(1)-(2), (b), (c), (d), and (e)

Specific Purpose:

The purpose of these amendments is to change the name of the PEI Component reports that the Counties are required to submit. These changes were made throughout these sections wherever the name of the reports are listed.

Rationale:

These non-substantive changes are necessary to simplify and shorten the name of the reports the counties are required to submit to the MHSOAC.

Section 3560.010(a)(1)

Specific Purpose:

The purpose of this amendment to subdivision (a)(1) is to change the due date of subsequent Annual Prevention and Early Intervention Report.

Rationale:

The amendment is necessary to better align the due date with the other fiscal and programmatic reports that a county is already required to submit. During the statewide implementation meetings counties indicated that the Prevention and Early Intervention reports dues dates were out of sync with their budgetary processes that they are required to complete before submitting the reports. Changing this due date facilitates conformity with other county due date requirements and will make the reporting process more streamlined for the counties.

Section 3650.0010(a)(2)

Specific Purpose:

The purpose of this amendment to subdivision (a)(2) is to provide an example and thus clarify the time frame for the data that is to be included in the Annual Prevention and Early Intervention Report.

Rationale:

This amendment is necessary to clarify for the County, given the new reporting due date, how to distinguish between the year the report is due and the year the data is from.

Section 3560.010(b)(2)(D)

Specific Purpose:

The purpose of this amendment to paragraph (D) of subdivision (b)(2) is to correct a non-substantive editing error.

Rationale:

The non-substantive amendment is necessary because the wrong word was used. The correct word is “principals” and not “principles.”

Section 3560.010(b)(3)(B)

Specific Purpose:

The purpose of this amendment to paragraph (B) of subdivision (b)(3) is to specify that the county is required to report a referral to treatment that is provided, funded, administered, or overseen by county mental health.

Rationale:

The amendment is necessary because during the statewide implementation meetings, counties expressed concern regarding the extent to which they would be required to report referrals. Of primary concern were referrals that were made to other entities, unrelated to the county behavioral health system (i.e. treatment facilities covered by private insurance). Because the county does not necessary have access to private facilities to collect relevant referral data this amendment specifies that the referrals the county is required to report for Access and Linkage Strategies or Programs, is to programs, treatment facilities or other entities, (community based organizations) over which the county exercises some authority, either through funding, administration or oversight responsibility.

Section 3560.010(b)(3)(F)

Specific Purpose:

The purpose of this amendment to add paragraph (F) to subdivision (b)(3) is to provide a definition of the term, “referral” for purposes of the reporting requirements for Access and Linkage to Treatment Strategy and Program.

Rationale:

This definition is necessary to address concerns raised by counties during the statewide implementation meetings. Counties reported that they have various ways of reaching out to and connecting with individuals with severe mental illness, including providing lists of community resources to those individuals. This definition is necessary to make clear what is and is not a referral for purposes of Access and Linkage to Treatment reporting requirements. A referral must be in writing and must be to one or more specific service providers. A list of available community resources does not constitute a referral for purposes of these reporting requirements.

Section 3560.010(b)(4)(G)

Specific Purpose:

The purpose of this amendment to add paragraph (G) to subdivision (b)(3) is to provide a definition of the term, "referral" for purposes of the reporting requirements for Improving Timely Access to Services for Underserved Populations Strategy and Program.

Rationale:

This definition, like the one in 3560.010(b)(3)(F), is necessary to address concerns raised by counties during the statewide implementation meetings. This definition is slightly different from that in subdivision (F) of 3560.010(b)(3) to be consistent with the reporting requirements in subdivisions (B) and (C) of section 3560.010(b)(4) that are specific to Improving Timely Access to Services for Underserved Populations Strategy and Program.

Section 3560.010(c)

Specific Purpose:

The purpose of this amendment to add subdivision (c) is to explicitly state that a county is responsible to collect and report demographic information for children under 18 years of age only to the extent permissible by applicable federal and state laws.

Rationale:

This amendment is necessary to address concerns raised by counties during the statewide implementation meetings. Counties voiced concern that programs serving children or youth younger than 18 years of age are often administered through or in partnership with California's schools which are subject to additional privacy laws. As such, this amendment is necessary to explicitly provide parameters to the county regarding the documenting and reporting requirements of demographic information for children and youth under 18 years of age.

Section 3560.010(d)

Specific Purpose:

The purpose of this amendment to add subdivision (d) is to specify that a county is not required to collect demographic data for children under the age of 12.

Rationale:

This amendment is necessary to establish a minimum age level threshold for demographic data collection. The minimum age threshold in this subdivision was chosen to be consistent with California Health and Safety Code section 124260 enacted in 2010 by Senate Bill 453 (Leno). Under section 124260, a minor who is 12 years of age or older may consent to outpatient mental health treatment or counseling, if in the opinion of the attending professional, the minor is mature enough to participate intelligently in the services. Section 124260 was enacted to eliminate barriers faced by youths eligible for mental health services specifically under the Prevention and Early Intervention component of the Mental Health Services Act.

Section 3560.010(e)

Specific Purpose:

The purpose of this amendment to add subdivision (e) is to authorize a county with a population under 100,000 to report the required demographic information for the entire Prevention and Early Intervention Component instead of by each Program or Strategy.

Rationale:

This amendment is necessary to address concerns raised by counties during the statewide implementation meetings. A key purpose of the demographic reporting requirement is to access to what degree programs are serving people who are from traditionally underserved communities. Because each program in very small counties tend to serve few consumers, the demographic information/summary statistics can vary wildly year to year and thus, can be misleading and will not accurately reflect who is being served. In addition, due to the population size, the data reporting requirements by program create a higher than average risk of inadvertent disclosure of individual identities. Allowing very small counties to report data for the entire Prevention and Early Intervention Component instead of by each Program or Strategy, addresses both of these issues.

Section 3560.020(a)

Specific Purpose:

The purpose of this amendment to subdivision (a) is to authorize a county to submit the Three-Year Prevention and Early Intervention Evaluation Report as part of the County's Annual Update and not just as part of the Three-Year Program and Expenditure Plan.

Rationale:

This amendment is necessary to be consistent with subdivision (a)(1) of section 3560.010 that permits a county to submit the Annual Prevention and Early Intervention report as part of either the Annual Update or the Three-Year Program and Expenditure Plan.

Section 3560.020(a)(1)

Specific Purpose:

There are three amendments to subdivision (a)(1). The purposes of those amendments are to: (1) authorize a county to submit the Three-Year Prevention and Early Intervention Evaluation Report as part of the County's Annual Update and not just as part of the Three-Year Program and Expenditure Plan; (2) change the due date for the Three-Year Prevention and Early Intervention Evaluation reports; and (3) specify the reporting period for the first Three-Year Prevention and Early Intervention Evaluation report.

Rationale:

The first amendment is necessary to be consistent with the amendment made in subdivision (a) of section 3560.020. The other two amendments are necessary to address concerns raised by counties during the statewide implementation meetings that the due date for the first Three-

Year Prevention and Early Intervention Evaluation report did not provide a county sufficient time to gather the data required to comply with the evaluation reporting requirements. Postponing the due date by six months and clarifying that the county is responsible for including data, if available, in the first report provides counties with flexibility and more time to collect and analyze the data for the first report.

The amendment is also necessary to change the due date of each subsequent Three-Year Prevention and Early Intervention Evaluation report to better align the due date with the other fiscal and programmatic reports that a county is already required to submit. During the statewide implementation meetings counties indicated that the Prevention and Early Intervention reports dues dates were out of sync with their budgetary processes that they are required to complete before submitting reports. Changing this due date facilitates conformity with other county due date requirements and will make the reporting process more streamlined for the counties.

Section 3705(a)(3)(A)1.

Specific Purpose:

The purpose of this amendment to subparagraph 1. of paragraph (A) of subdivision (a)(3) is to replace the word, "declaration" with the word, "resolution".

Rationale:

This non-substantive change is necessary to more accurately reflect the correct terminology and process by which County Board of Supervisors issue decisions.

Section 3705(a)(4)(A) and (a)(4)(B)

Specific Purpose:

The purpose of this amendment is to add paragraphs (A) and (B) to subdivision (a)(4) is to provide a county with a population under 100,000 a way to opt out from the requirement to offer an Access and Linkage to Treatment Program.

Rationale:

The rationale for providing an opt out option for small counties from the requirement to offer an Access and Linkage to Treatment Program is that due to their small population, requiring an Access and Linkage to Treatment Program in addition to the required Access and Linkage to Treatment Strategy within each Prevention and Early Intervention Component program might not be feasible and may dilute the small counties' efforts with more limited funds available.

Section 3705(c)

Specific Purpose:

The purpose of this amendment to add subdivision (c) is to provide a county with a population under X an option to combine and/or integrate the five required programs: Early Intervention, Prevention, Access and Linkage to Treatment, and Stigma and Discrimination Reduction.

Rationale:

The rationale for providing an option for very small counties to combine and/or integrate the five required programs rather than providing five separate, stand-alone programs is that these very small counties lack the staff resources to adequately implement, monitor and support separate programs in each Prevention and Early Intervention programmatic area. Stand-alone programs restrict a county's flexibility in responding to the needs of local consumers, while disproportionately raising very small counties' overhead costs of delivering services within distinct program categories. This option to combine and/or integrate the five required programs does not eliminate the requirement for these counties to provide services in these five programmatic areas.

S**ection 3726(b)**

Specific Purpose:

The purpose of the amendment to subdivision (b) is to be consistent with the amendments made to subdivision (b)(3)(B) of section 3560.010 that specify the county is required to report a referral to treatment that is provided, funded, administered, or overseen by county mental health.

Rationale:

The amendment is necessary to be consistent with the amendments made to subdivision (b)(3)(B) of section 3560.010.

Section 3726(e)

Specific Purpose:

The purpose of the amendment to add subdivision (e) is to allow an Access and Linkage to Treatment Program to be provided through other Mental Health Services Act component as long as it meets all the section 3726 requirements.

Rationale:

This amendment is necessary to address concerns raised by counties during the statewide implementation meetings. Some counties already provide access and linkage-like services through Community Services and Supports (CSS), another Mental Health Services Act component. This amendment is necessary to provide flexibility and not create a situation where a county is required to provide duplicative services.

Section 3735(a)(1)(A)

Specific Purpose:

The purpose of the amendment to paragraph (A) of subdivision (a)(1) is to be consistent with the amendments made to subdivision (b) of section 3726 and subdivision (b)(3)(B) of section 3560.010 that specify the county is required to report a referral to treatment that is provided, funded, administered, or overseen by county mental health.

Rationale:

The amendment is necessary to be consistent with the amendments made to subdivision (b) of section 3726 and subdivision (b)(3)(B) of section 3560.010.

Section 3750(f)(1)-(4) and 3750(g)(1)-(3)

Specific Purpose:

These amendments provide a cross-reference to the new definitions of referral in 3750(b)(3)(F) and 3750(b)(3)(G).

Rationale:

These amendments are necessary to provide internal cross-references to the new definitions.

Section 3750(k)

Specific Purpose:

The purpose of the amendment to add subdivision (k) is to specify the method that a county that opted to combine and/or integrate programs as authorized in subdivision (c) of section 3705 may use to satisfy the evaluation requirements in subdivisions (a) through (g) of section 3750.

Rationale:

This amendment is necessary to provide needed guidance with regard to how to measure the effectiveness of the combined programs and to be consistent with the authorization under subdivision (c) of section 3705. A county that has opted to combine and/or integrate programs as authorized by 3705(c) is still required to report outcomes, however, because the programs are combined the county cannot comply with the current section 3750 because the requirements are for individual programs. The outcomes that must be measured are consistent with the requirements in other subdivisions of section 3750 because they must evaluate the negative outcomes referenced in Welfare and Institutions Code section5840, subdivision (d).Thus, the amendment is necessary. The counties, are, however able to determine the criteria and measurements for these evaluations as long as they address the negative outcomes that are identified in the Act.

Section 3755(c)-(l)

Specific Purpose:

The purpose of the amendments to subdivisions (c) through (l) inclusive, is to specify that the requirements in these subdivisions are limited by the provisions in subdivision (o) of section 3755.

Rationale:

These changes are necessary to be consistent with the exceptions to the requirements set forth in the section.

Section 3755(o)(1) – (9)

Specific Purpose:

The purpose of the amendment to add subdivision (o) is to specify the information that a county, that opted to combine and/or integrate programs as authorized by 3705(c), is required to include in its Three-Year Program and Expenditure Plan and Annual Update.

Rationale:

This amendment is necessary to be consistent with the authority granted under subdivision (c) of section 3705. The information required under subdivision (o) is necessary to ensure that local decision-makers, including County Mental Health Boards and Boards of Supervisors, have the requisite information to conclude the county's planned combined and/or integrated programs and evaluation meet the MHSA and the regulatory requirements.

Subdivision (o)(1) is necessary to ensure the local decision-makers and the MHSOAC has an accurate description of the programs.

Subdivisions (2) through (4) are necessary to help ensure that the combined and/or integrated programs address the negative outcomes that may result from untreated mental illness enumerated in Welfare and Institutions Code section 5840, subdivision (d). These requirements are also necessary to provide the MHSOAC with information necessary to track statewide the programs that are aiming to reduce each of the seven negative outcomes for purposes of communication and as foundation for local and statewide evaluation and quality improvement. Providing the county the flexibility to determine applicable indicators is appropriate because of the variability of Prevention and Early Intervention programs statewide.

Subdivisions (5) and (6) are necessary to help ensure that the combined and/or integrated programs comply with the requirements in the regulations.

Subdivision (7) is necessary to provide local decision-makers with information about the estimated reach of programs across the lifespan, cost-effectiveness of programs, and cost per person. With this information local decision-makers can determine the best use of Prevention and Early Intervention funds, including if more funds should be spent on programs that are estimated to serve a higher number of people.

Subdivisions (8) and (9) are necessary to provide essential information to local decision-makers and transparency to constituents, and provides the MHSOAC information necessary to track planned expenditures. The requirement to document he expected administrative cost is necessary to help ensure that sufficient funds are available for direct services. Cumulatively, these requirements are necessary to help ensure accountability to taxpayers and to the public.

Mental Health Services Oversight and Accountability Commission Meeting
July 27, 2017

In October 2016 the Mental Health Services Oversight and Accountability (MHSOAC) adopted the report, *Finding Solutions, Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act.* To implement some of the recommendations in the report, the Subcommittee on Prevention and Early Intervention and Innovation Regulations at its June 1, 2017 meeting considered proposed amendments to the Prevention and Early Intervention and the Innovative Project regulations to be submitted to the MHSOAC. The proposed amendments to the Innovative Project regulations set forth below are necessary in order to be consistent with the proposed amendments to the Prevention and Early Intervention regulations. The proposed amendments are set forth below and are shown in underlined text (new language) and strikethrough text (deleted language).

Article 5. Reporting Requirements

Amend Section 3580 as follows:

Section 3580. Innovative Project Reports.

(a) For each approved Innovative Project, the County shall submit to the Mental Health Services Oversight and Accountability Commission the following reports, as applicable.

(1) For a continuing Innovative Project, an Annual Innovative Project Report as specified in Section 3580.010.

(A) The first Annual Innovative Project Report is due no later than December 31, 2017 ~~following the end of the fiscal year for which the County is reporting.~~ The County may submit the Annual Innovative Project Report as part of the Three-Year Program and Expenditure Plan or Annual Update. ~~as long as the documents are submitted no later than December 31 pursuant to this subdivision.~~ Each Annual Innovative Project Report thereafter is due to the Mental Health Services Oversight and Accountability Commission as part of the Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisor approval but no later than June 30 of the current fiscal year whichever occurs first.

(B) The County shall exclude from the Annual Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

a. A supplemental Annual Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
b. A supplement to the Annual Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".

(2) Upon completion of an Innovative Project, a Final Innovative Project Report as specified in Section 3580.020.

(A) The County may submit the Final Innovative Project Report as part of the Three-Year Program and Expenditure Plan, Annual Update, or within six months from completion of the Innovative Project whichever is closest in time to the completion of the Innovative Project.

(B) The County shall exclude from the Final Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:
   a. A supplemental Final Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
   b. A supplement to the Final Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830 and 5847, Welfare and Institutions Code.

Adopt Section 3580.010 as follows:

Section 3580.010. Annual Innovative Project Report.

(a) The Annual Innovative Project Report shall include:

(1) Name of the Innovative Project

(2) Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.

(3) Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.

(4) Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served by:

(A) Age by the following categories:

1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:

1. Hispanic or Latino as follows
   a. Caribbean
   b. Central American
   c. Mexican/Mexican-American/Chicano
   d. Puerto Rican
   e. South American
   f. Other
   g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used by threshold languages for the individual county

(E) Sexual orientation,

1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual

4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) A Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

1. Yes, report the number that apply in each domain of disability(ies)
   a. Communication domain separately by each of the following
      (i) Difficulty seeing
      (ii) Difficulty hearing, or having speech understood
      (iii) Other (specify)
   b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
   c. Physical/mobility domain
   d. Chronic health condition (including but not limited to chronic pain)
   e. Other (specify)
2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,

1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender

1. Assigned sex at birth
   a. Male
   b. Female
   c. Number of respondents who declined to answer the question
2. Current gender identity
   a. Male
   b. Female
   c. Transgender
   d. Genderqueer
   e. Questioning or unsure of gender identity
   f. Another gender identity
   g. Number of respondents who declined to answer the question

(5) Any other data the County considers relevant.

(b) For an Innovative Project serving children or youth younger than 18 years of age, the demographic information required under subdivision (a)(4) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California

Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(c) A county is not required to collect the demographic information required under subdivision (a)(4) of this section from a minor younger than 12 years of age.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

Mental Health Services Oversight and Accountability Commission

Initial Statement of Reasons
Innovative Project
AMENDMENTS TO INNOVATIVE PROJECT REGULATIONS

SUBJECT MATTER OF PROPOSED REGULATIONS:

Innovative Project of the Mental Health Services Act.

SECTIONS AFFECTED: 35860, 3580.010

PROBLEM STATEMENT

California voters approved Proposition 63 in the November 2004 General Election. Proposition 63 became effective on January 1, 2005 as the Mental Health Services Act (MHSA). The MHSA intends to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness through imposition of a 1% tax on personal income in excess of $1M.

The MHSA established the Mental Health Oversight and Accountability Commission (MHSOAC) to oversee the community mental health system and the new programs established by the MHSA, including Innovative Project.

In 2013 the MHSOAC was charged, as the result of Assembly Bill 82, (Committee on Budget, Chapter 23, Statutes of 2013) to develop and promulgate regulations for the Innovative Project component of the MHSA. Those regulations were completed and went into effect October 1, 2015. In the months following the October 1, 2015 promulgation of the Innovative Project regulations, representatives of California's county behavioral health agencies raised multiple concerns about their ability to comply with some of the new regulations. During 2016 the MHSOAC conducted a series of public meetings throughout the state to gather information on the specific implementation challenges and strategies to address those challenges. The proposed amendments to the regulations are a result of this yearlong public input process (hereinafter "statewide implementation meetings").

PURPOSE AND REASONABLE NECESSITY OF AMENDMENTS TO REGULATION

The amendments are reasonably necessary to address the challenges and barriers to implementing the regulations that were identified in the statewide implementation meetings.

BENEFITS

This regulatory proposal, amending sections of the Innovative Project regulations, first promulgated in 2016, helps to ensure that California's county behavioral health agencies, the entities responsible to comply with the regulations issued in 2016, are better able to comply with those regulatory requirements. The initial regulations provided for the first time statewide consistency and conformity in the administration and reporting of Innovative Project data and evaluation that enables the MHSOAC to conduct more effective oversight and evaluation of the projects. Better compliance with the regulations ultimately will help to increase the quality of mental health services programs.

STATEMENT FOR EACH PROPOSED ADOPTION, AMENDMENT, OR REPEAL

The following sections set forth the specific purpose of each amended regulation and the rationale for the MHSOAC's determination that each amendment is reasonably necessary to carry out the purpose for which it was proposed.

Section 3580

Specific Purpose:

The purpose of this amendment to paragraph (A) of subdivision (a)(1) is to change the due date of subsequent Annual Innovative Project Report.

Rationale:

The amendment is necessary to better align the due date with the other fiscal and programmatic reports that a county is already required to submit. During the statewide implementation meetings counties indicated that the Innovative Project reports dues dates were out of sync with their budgetary processes that they are required to complete before submitting the reports. Changing this due date facilitates conformity with other county due date requirements and will make the reporting process more streamlined for the counties.

Section 3580.010(b)

Specific Purpose:

The purpose of this amendment to add subdivision (b) is to explicitly state that a county is responsible to collect and report demographic information for children under 18 years of age only to the extent permissible by applicable federal and state laws.

Rationale:

This amendment is necessary to address concerns raised by counties during the statewide implementation meetings. Counties voiced concern that programs serving children or youth younger than 18 years of age are often administered through or in partnership with California's schools which are subject to additional privacy laws. As such, this amendment is necessary to explicitly provide parameters to the county regarding the documenting and reporting requirements of demographic information for children and youth under 18 years of age.

Section 3560.010(c)

Specific Purpose:

The purpose of this amendment to add subdivision (c) is to specify that a county is not required to collect demographic data for children under the age of 12.

Rationale:

This amendment is necessary to establish a minimum age level threshold for demographic data collection. The minimum age threshold in this subdivision was chosen to be consistent with California Health and Safety Code section 124260 enacted in 2010 by Senate Bill 453 (Leno).

Under section 124260, a minor who is 12 years of age or older may consent to outpatient mental health treatment or counseling, if in the opinion of the attending professional, the minor is mature enough to participate intelligently in the services. Section 124260 was enacted to eliminate barriers faced by youths eligible for mental health services specifically under the Mental Health Services Act.

AGENDA ITEM 3

Action
July 27, 2017 Commission Meeting

MHSOAC Budget Approval

Summary: The Commission will consider approval of the Mental Health Services Oversight and Accountability 2017-18 Budget.

Presenter(s): Norma Pate Deputy Director

Enclosures: None

Additional Materials (1): A PowerPoint will be provided at the meeting.

Proposed Motion: The Commission approves the Commission's 2017-18 Budget.

AGENDA ITEM 4

Action
July 27, 2017 Commission Meeting

2017-18 MHSOAC Legislative Report

Summary: Commissioner's will be provided with an update on legislative bills that the Commission sponsored and support in 2017.

Presenter(s): Norma Pate Deputy Director

Enclosures: None

Additional Materials (1): A PowerPoint will be provided at the meeting.

Proposed Motion: None

AGENDA ITEM 5

Information

July 27, 2017 Commission Meeting

7 Cups of Tea

Summary: The Mental Health Services Oversight and Accountability Commission has invited Dr. Glen Moriarty, founder and CEO of 7Cups.com, to present on 7 Cups, a Web-based network of individuals who provide online behavioral support services. Innovation in the delivery of mental health services is a goal of the Mental Health Services Act and information about new and innovative methods is vital for support of transformational change in mental health. Dr. Moriarty will present the background, outcomes, and future potential for innovation for the 7 Cups of Tea model in California.

Presenters: Glen Moriarty, Psy.D.

Enclosures: None

Handouts: *7 Cups: Connected Care*, slides

Recommended Action: Information item only

AGENDA ITEM 6

Action
July 27, 2017 Commission Meeting

Senate Bill (SB) 82 Investment in Mental Health Wellness Act Request for Applications (RFA) principles

Summary: Mental Health Services Oversight and Accountability Commission will seek input on and consider adopting the following principles to guide the drafting of the next Senate Bill (SB) 82 Triage Grant Request for Applications (RFA):

- **Evaluation Strategy.** To fortify the evaluation of Triage investment, the Commission will consider centralizing the evaluation of Triage grants for the second round of grants.
- **Set Aside for Children's Triage Funding**. During the first round of Triage funding, few counties applied for funds to address the needs of children. The Commission will consider designating a set aside for children's services for the second round of grants.
- **Population Based Apportionment.** In the first round of triage funding, the Commission used the California Behavioral Health Care Directors Association regions and the Department of Health Care Services Mental Health Services Act distribution formula to apportion the funds. The Commission will consider using a population based apportionment formula for the second round of grants.

These principles will be discussed and voted on at the July 27, 2017 Commission meeting in Sacramento.

Presenter(s): Toby Ewing, Executive Director; Norma Pate Deputy Director; Tom Orrock, Triage Manager; Kristal Antonicelli, Project Lead

Enclosures: None

Additional Materials: A PowerPoint will be provided at the meeting

Proposed Motion: The Commission adopts the principals to address the following:

- Evaluation Strategy
- Set Aside for Children's Triage Funding
- Population Based Apportionment

AGENDA ITEM 08

Action

July 27, 2017 Commission Meeting

Yolo County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Yolo County's request to fund the following new Innovative projects for a total amount of $1,814,264 (see below for project breakdown). The total duration of the Board and Care Study Project is one (1) year and the total of three (3) years for the First Responders Initiative Project.

(A) **Board and Care Study Project-** $89,125

(B) **First Responders' Initiative - $**1,725,139

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.

- Yolo County proposes using Innovation funds to gather and analyze data to investigate how to alleviate major factors impacting Board and Care homes availability in Yolo County and to design and implement strategies based upon the outcomes of the data collection.
- Yolo County also proposes using Innovation funds to develop a multi-disciplinary team integrating law enforcement first responders and non-law enforcement first responders into a multi-disciplinary team (MDT).

Presenter(s):

- Karen Larsen, LMFT, Yolo County Health and Human Services Agency, Mental Health Director
- Joan Beesley, MA, Yolo County Health and Human Services Agency, MHSA Programs Coordinator
- Roberta Chambers, PsyD, Project Manager, Resource Development Associates (RDA)
- Sandra Sigrist, LCSW, Yolo County Health and Human Services Agency, Branch Director for Adult and Aging Programs

Enclosures: (1) Staff Summary, Board and Care Study Project Yolo County; (2) County Project Brief, Board and Care Study; (4) Staff Summary, First Responders Initiative; (5) County Project Brief, First Responders Initiative.

Handout: PowerPoint presentation

Additional Materials (1): Links to the County's complete Innovation Plans are available on the MHSOAC website at the following URL:
http://mhsoac.ca.gov/document/2017-07/yolo-county-inn-plan-description-board-and-care-study-project

http://mhsoac.ca.gov/document/2017-07/yolo-county-inn-plan-description-first-responders-initiative

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

Name: Board and Care Study Project
Amount: $89,125
Project Length: One (1) Year

Name: First Responders Initiative
Amount: $1,725,139
Project: Length: Three (3) Years

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 661-2750 • www.yolocounty.org

Biographies for Yolo County Innovation Presenters

Karen Larsen, Director, Yolo County Health and Human Services Agency (HHSA). For more than two decades, Karen has provided behavioral health services to the underserved of Yolo County and its surrounding areas. As a woman in recovery, Karen has strived to educate partners throughout California on the benefits of treating substance use disorders as a chronic health condition, rather than a moral deficit. Over the years, Karen's focus has expanded from serving individuals with substance use disorders to assisting systems to achieve integrated care for those with physical health, mental health, and substance use disorders, while improving the agency's overall financial sustainability. Her passion for integrated care brought Karen to Yolo County, where she came aboard as the county's Mental Health Director and Alcohol & Drug Administrator in March 2014, just as the agency was integrating the Departments of Health, Employment and Social Services, and Alcohol, Drug and Mental Health. In May 2016, Karen accepted the position of Director of Yolo County's integrated Health and Human Services Agency. Karen works closely with county staff and community stakeholders to assist Yolo County residents in achieving healthy, safe and economically stable life circumstances. The Agency's strategic plan identifies goals intended to improve outcomes for clients and community; ensure fiscal health; strengthen HHSA integration; make data-informed decisions; and, create a culture of quality. Karen is active in local and statewide groups engaging in cross-system collaboration to address social determinants of health for vulnerable populations. She also serves on the Board of Directors for the California Institute for Behavioral Health Solutions, and Yolo County Children's Alliance. Additionally, Karen is a member of Yolo County's Community Corrections Partnership.

Roberta Chambers, PsyD Dr. Chambers provides strategic direction, oversight, and project management for a portfolio of planning and evaluation projects with Resource Development Associates. With a background in direct service provision, Dr. Chambers has worked extensively throughout California and nationally to design, implement, and evaluate programs that support people with serious mental illness and/or developmental disabilities to remain in or transition back to the community from institutional settings, such as jails and hospitals. Clinically, her experience is based in the public sector with a focus on people with serious INNmental illness, substance use, forensic involvement, and/or an intellectual disability. She has presented nationally on promising practices in participatory planning and evaluation, deinstitutionalization, and assisted outpatient treatment. She co-chairs RDA's Institutional Review Board and is adjunct faculty in the PsyD program at JFK University in Pleasant Hill.

Sandra Sigrist, **LCSW**, has worked with Yolo County Health and Human Services since September, 2014, originally as a Clinical Program Manager, advancing to serve in the role of Branch Director for Adult & Aging Programs in May, 2016. In her current role, she holds responsibility for the planning, organization, implementation and supervision of multiple programs, including Behavioral Health, In-Home Support Services, Public Guardian and the County Veteran Services Office. Sandra has over 25 years of experience in direct and administrative oversight of clinical programs, having received her Master's Degree in Social Work in 1988. She holds a particular interest in establishing strong collaborations for the benefit of individuals receiving services across a broad continuum of care. Her areas of interest include Results Based Accountability Performance Measures, creative application of evidenced-based practices, effective implementation of homeless intervention strategies and treating the whole person.

Joan Beesley, M.A., was hired by Yolo County's Children's Mental Health Department in 1998, as the Family Partnership Coordinator, serving parents and caregivers who, like she, had children with serious emotional difficulties. Following the passage of Proposition 63 in 2004, she was appointed MHSA Coordinator for Yolo County, and in 2008, Joan was promoted to MHSA Program Manager. A Yolo resident since 1978, and a local person with lived experience as a family member, Joan has spent the last dozen years working to involve community stakeholders in the development and improvement of MHSA programs that serve our community, educate our community about mental illness, and reduce stigma against individuals with mental illness.

STAFF INNOVATION SUMMARY — YOLO COUNTY

Name of Innovative (INN) Project: Board and Care Study Project

Total INN Funding Requested for Project: $89,125

Duration of Innovative Project: One (1) Year

Review History

Approved by the County Board of Supervisors: April 4, 2017
County Submitted Innovation (INN) Project: May 9, 2017
MHSOAC Consideration of INN Project: July 27, 2017

Project Introduction:

Yolo County proposes to use Innovation funds to conduct a Board and Care study project to assess and address the need for additional supervised environments with ancillary services including case management, social rehabilitation, and medication monitoring.

There are specific criteria that the OAC addresses 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 directly to the need?; And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? Additionally, the OAC must verify that the Innovation meets regulatory requirements, ensures the proposed project aligns with the core MHSA principles, promotes 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 Yolo County, their Board and Care (B&C) facilities are less likely to accept individuals living with severe mental illness (SMI). Yolo County states they seek to lessen the need to place these individuals outside of Yolo County, away from their support networks, in order to find facilities willing to provide housing. The County states this reflects the significant shortage of beds for high-need clients and restricts the client's ability to interact with their clinicians and family member that can impede the client's wellness process. The County reports two (2) out of the eight (8) B&C homes in Yolo County designate themselves for individuals living with SMI and can host only twenty-eight clients. According to Yolo County, they refer many individuals living with SMI to B&Cs out of County.

Previously, Yolo County addressed the B&C shortage using patch funding; however, the results were short-term. Yolo County states they need to explore the factors and theories of why there is a shortage of B&C in their County. The County would like to study the various factors that may be contributing to the shortage of B&C homes to determine which factor(s) are the most relevant and feasible to address. The County seeks to consider testing the following factors: quality of care, financial sustainability, access to resources, cultural and linguistic competencies for care in B&Cs, nimbyism as a method for controlling where not to place B&Cs in Yolo County, provider access to clients, and ensuring quality of care for persons funded through Medi-Cal, Medicaid, or other government programs versus private funding.

The County has stressed the inability to utilize data driven assessments to understand the lack of B&Cs and wants to conduct a study project to develop changes or improvements to this process. Furthermore, the County seeks to improve the quality of services, improve recovery and treatment outcomes, and increase access to B&Cs resulting in increased access to services and ultimately increasing the number of care facilities accepting consumers; the latter proving to be more challenging and require additional funding and support services. In addition, Yolo County hopes to learn if the project will contribute to developing best practices, policy improvements, or procedural changes for all California counties.

The Response

The County's *Board and Care Study Project* has two phases. Phase I encompasses the project launch, data collection and analysis, and strategic planning while Phase II will focus on implementation. The first phase is a yearlong investigation of factors influencing the lack of availability and access to B&Cs in Yolo County for SMI clients. At this time, the County seeks approval to use Innovation funds to complete Phase I. Yolo County intends to use the information obtained in Phase I to develop Phase II of the project and seek approval for additional MHSA Innovation funds to support parts of Phase II.

Yolo County reports Phase I will employ an evidence-based decision-making process to develop the strategies they will implement in Phase II of the project. They will use data analytics to analyze information gathered in Phase I. The County reports a plan to engage with consumer, family member, and other key stakeholders throughout the project to obtain and review data collected to

The County indicates conducting an extensive literature review process, resulting in limited studies reviewing the various reasons most counties in California are experiencing a shortage of B&C homes and effective strategies addressing this need. It appears this study may lead to the development of new practices, policies, programs, or adapted techniques to bring new or additional knowledge to the mental health field related to housing.

The Community Planning Process

The MHSA regulations indicate stakeholder participation will be present at every step of the way during the Innovation project, including the Community Planning Process (CPP).

During the CPP, counties should provide training, where needed, to ensure meaningful participation by consumers with SMI and/or serious emotional disturbances, along with their family members. This subsection should clarify what evidence the County presents for meeting this requirement.

Yolo County incorporated developing this Innovation concept with their stakeholders in conjunction with the submission of their 2017-2020 MHSA Three-Year Plan.

Yolo County reports conducted an extensive outreach effort utilizing a multitude of client-centered materials (also made available in Spanish), activities, phone calls, announcements, and a summit. The County states these efforts resulted in widespread stakeholder interest, participation, and involvement. The County reports participants included: homeless, LGBTQ, TAY, older adults, consumers and family members, peer support workers, county staff, mental health providers, law enforcement, veterans, and multiple service agencies.

Learning Objectives and Evaluation

This section addresses the degree to which the County plans 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.

Yolo County reports they will gather information related to racial disparities, economic factors, reasons for fines and citations, and exclusionary practices in B&C homes in their County. The County reports this data will support determining the root causes for the lack of sufficient, high quality, in-county B&Cs to house individuals living with SMI. At the end of both Phase I and II, the County intends to assess and learn about best practices for quality, type, size, location, environments, staff pattern, training needs, and length-of-stay standards for B&Cs housing individuals living with SMI.

It appears Yolo County seeks to develop effective strategies to motivate Yolo County's B&Cs to increase the number of beds for individuals living with SMI, provide high quality and effective care for intense mental health needs for these individuals, and develop training to build staff capacity to effectively care for consumers within the local County boundaries. It appears evaluators (contractors) will incorporate quality improvement, consumer and provider feedback, and process and outcome measures to achieve these learning objectives.

The Budget

Yolo County is proposing a one-year project study with a total cost of $89,125. The proposal includes $31,750 for a 0.1 FTE Program Manager and a 0.1 FTE Analyst. These positions appear under the Yolo County Health and Human Services Agency. The Program Manager, with assistance from the Analyst, will coordinate personnel working on related projects, track timelines, and monitor progress. The budget also includes administrative costs, for a total of $11,625, which is 13% of the total budget. It is unclear

if the two personnel positions is considered administrative costs given their role and duties in the project.

Yolo County will hire an outside consultant, to provide majority of the services, with a total budget of $45,750 (51% of the total Innovation project budget). The County has not provide a separate budget for evaluation and reports incorporating the cost of evaluation under the contractor fees.

Additional Regulatory Requirements

The proposed project appears to meet the minimum regulatory requirements as stated in MHSA Innovation regulations.

References

Residential Environment and Quality of Life Among Seriously Mentally Ill Residents of Board and Care Homes; Mares, A.S., Young, A.S., McGuire, J.F. et al. Community Mental Health J (2002) 38: 447. doi:10.1023/A:1020876000860

Quality of Mental Health Care for Nursing Home Residents: A Literature Review
David C. Grabowski,1 Kelly A. Aschbrenner,2 Vincent F. Rome,1 and Stephen J. Bartels2

Accordino MP, Porter DF, Morse T. Deinstitutionalization of persons with severe mental illness: Context and consequences. Sage Journal of Rehabilitation. 2001;67(2):16–21.

Board and Care Study Project

Statement of Need

During the Community Program Planning (CPP) process to develop the MHSA Three Year Program and Expenditure Plan 2017-2020, stakeholders identified a lack of housing options for people with the most intense service needs as a primary problem, specifically the extreme shortage of Board and Care facilities.

Yolo County Health and Human Services Agency (HHSA) leadership and community stakeholders identified three interwoven factors that present major challenges to providing an appropriate level of housing assistance and supports to adult consumers with the most intense service needs.

There are not enough Board and Care Facilities in Yolo County.

In Yolo County, there are only eight adult residential facilities to serve Yolo County residents (**Error! Reference source not found.**), some of which are targeted to people with developmental disabilities. The current available bed space (capacity of 18) is not sufficient to meet the high need for board and care for persons with serious mental illness. Historically, many board and care facilities have closed down in Yolo County. Of the remaining board and care homes, only a few provide bed space for adults with serious mental illness (SMI).

1. Table 1. Board and Care Homes in Yolo County[1]

Facility	Population Served	Capacity	Years in Operation
Pine Tree Gardens West	Individuals with SMI	15	7
Pine Tree Gardens East	Individuals with SMI	13	7
Davis Summer House	Individuals with Developmental Disabilities	14	24
Summer House Inc.	Individuals with Developmental Disabilities	12	42
E & J Griffin Family Care Home	Individuals with Developmental Disabilities	6	20
E & J Griffin Family Care Home II	Individuals with Developmental Disabilities	6	12
Tropical Villa-ARF	Individuals with Developmental Disabilities	6	12
V & P Truong Care Home, LLC	Individuals with Developmental Disabilities	4	6
Total and Range		76	6 – 42

[1] California Department of Social Services. Licensed Facility Search. Accessed on March 21, 2017 from https://secure.dss.ca.gov/CareFacilitySearch/.

Due to the limited amount of Board and Care Facilities, Board and Care Facilities are less likely to accept clients with more intensive needs.

Since bed capacity is limited, there may be competition for board and care beds that makes it more likely for board and care facilities to accept consumers who are relatively easier to serve, require less support to adapt to a group living situation, and follow board and care facility rules with minimal difficulty. Currently, there are no incentives for board and care facilities in Yolo County to take on mental health consumers with higher service needs. Facilities are generally reticent to house consumers with mental health challenges, since staff may not have the mental health knowledge or capacity to support consumers' needs. Furthermore, adults with serious mental illness who are unable to secure housing in a board and care facility end up living in a board and care home outside of the county, living with aging parents or other family, living in other arrangements that don't provide needed support (e.g., room and board), or living on the streets. As the population in Yolo County continues to age, there is an additional threat that a large number of adults with serious mental illness may no longer be able to live with their aging parents or family. This may further exacerbate the issue and have significant ramifications to the community and adult mental health system.

Mental health consumers with the highest needs are placed out of county and away from their homes and families and/or support system.

The board and care facility shortages disproportionately impact those with the highest level of need. Without adequate Board and Care facilities within the County, Yolo County residents who require that support to live in the community are placed in out-of-county facilities. This creates a variety of challenges, including:

- Consumers are farther away from their families, other natural supports, and health and mental health services, which creates barriers to their recovery and support.
- Consumers with the highest level of need are less likely to be accepted for a Board and Care placement by the facility when there are consumers with less intense needs also competing for the available bed.
- County staff have to travel further distances to meet with the consumers, which makes it more difficult to monitor quality as well as provide support to the consumer and Board and Care staff.
- Medi-Cal and other benefits connected to a person's county of residence may be switched creating unnecessary challenges for the consumer as well as administrative burdens to staff.

Understanding of the Problem

The County and stakeholders attempted to identify potential solutions to address the Board and Care shortage, and realized that:

1. This was a complex problem that required further research to understand the intersecting factors that contribute to the board and care shortage, and
2. That addressing the Board and Care shortage would require creative solutions informed by an accurate understanding of the factors that contribute to the problem.

Evidence to inform successful strategies for expanding board and care bed capacity is very limited, and evidence regarding innovative strategies is even more limited.[2] Furthermore, Yolo County has historically addressed the problem using patch funding, but this approach has only yielded short term results and shortages continue to persist. Thus, Yolo County and MHSA stakeholders identified the need to develop a better understanding of the factors influencing board and care shortages, which will inform evidence-based and long-term strategies that address underlying factors contributing to the shortages. The challenges around board and care facilities discussed above are not unique to Yolo County. Although other counties in California have experienced similar issues, particularly in mid-sized counties, no other counties in California have employed rigorous data-informed strategic planning.

Proposed INN Project

The County, in partnership with their stakeholders, developed this innovation project with the intention of engaging in a rigorous, participatory study to develop a more thorough and accurate understanding of the problem and convene an interdisciplinary workgroup to develop creative solutions to address the problem. The Board and Care Study Project seeks to explore and address the issues identified by Yolo County stakeholders around access to board and care services.

The Board and Care Study Project seeks to achieve the following learning goals:

- Increase understanding of the dynamics underlying the board and care bed shortage;
- Identify strategies and incentives to increase the board and care bed capacity;
- Identify capacity building approaches to incentivize the placement of consumers with the most intense service needs in available board and care beds; and
- Develop an implementation plan to increase access to board and care placement for those with the most intense service needs.

Through this project, HHSA plans to gather qualitative data from consumers, their families, board and care operators, Community Care Licensing, and mental health providers; conduct a quantitative analysis of people currently placed or at-risk of placement in out-of-county facilities; and conduct benchmarking interviews with other jurisdictions to identify potential strategies. HHSA then plans to engage stakeholders to use the data gathered to develop creative and actionable strategies to increase the Board and Care capacity within the County. Following the study project, HHSA plans to implement the strategies developed to increase Board and Care capacity within the County. The County is committed to effectively addressing this problem and understands that the solutions identified by this project may not meet criteria for additional INN funds. As such, the County will work to identify and commit funds to implement the solutions identified with this project and will only request additional INN funds for those strategies that meet INN requirements.

[2] Wunderlich, G.S., and Kohler, P.O. (2001). *Improving the Quality of Long-Term Care*. Institute of Medicine Committee on Improving Quality in Long-Term Care. National Academic Press. Washington, D.C.

By implementing the Board and Care Study Project, Yolo County will be able to:

1. Improve understanding of the multiple factors influencing access and availability of board and care facilities in Yolo County.
2. Develop a plan to expand Board and Care capacity within the County that is directly responsive to the identified contributing factors.

Findings from the Board and Care Study Project will provide new information about how to best address Board and Care shortages in Yolo County as well as similar counties facing the same challenges. This project will also provide a model for a data-driven approach to addressing complex barriers in access and availability of board and care bed space, particularly for adults with serious mental illness. In addition, the evaluation will assess the impact and importance of the Board and Care Study Project, which contributes to new knowledge from which further data-driven innovations can emerge. Ultimately, the learning from this project may contribute to widespread practice or policy changes.

The Board and Care Study Project (BCSP) activities, which constitutes the first phase of a long-term strategy envisioned by Yolo County, will be followed by a separate project focused on the implementation of strategies identified in the BCSP. **Phase I: Board and Care Study Project** will investigate factors influencing availability and access to board and care services in Yolo County, and utilize findings to inform the development of Phase II INN Planning. During **Phase II: Implementation**, Yolo County will seek additional funding sources to support implementation activities, including MHSA Innovation funds, if applicable. In order to contextualize the BCSP within the scope of the long-term vision, plans for both Phase I (i.e., Board and Care Study Project) and Phase II (i.e., Implementation) will be described in this document. **Error! Reference source not found.** summarizes the activities and processes planned for addressing board and care facility shortages in Yolo County.

STAFF INNOVATION SUMMARY — YOLO COUNTY

Name of Innovative (INN) Project: First Responders Initiative (FRI)

Total INN Funding Requested for Project: $1,725,139

Duration of Innovative Project: Three (3) Years

Review History

Approved by the County Board of Supervisors: April 4, 2017
County Submitted Innovation (INN) Project: May 9, 2017
MHSOAC Consideration of INN Project: July 27, 2017

Project Introduction:

Yolo County proposes using Innovation funds to modify a current practice of using multi-disciplinary teams (MDT) to respond to crisis by incorporating non-law enforcement personnel into MDT teams and to establish an alternate location to divert individuals in a crisis, both with the intent to improve Yolo's crisis continuum of care.

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

Yolo County reports law enforcement receive more than 4,000 calls yearly (average eleven calls per day). Through SB 82/Triage funds, the County sought to address this issue by establishing the Crisis Intervention Program (CIP) that paired clinical staff with law enforcement to respond to mental health crisis. The County reports their SB82 program has successfully reduced unnecessary visits to the local emergency department for psychiatric hospitalization and improved the collaboration between mental health and law enforcement. The County reports the impact is limited given many non-law enforcement first responders face similar situations with limited knowledge of how to address the mental health needs of the individuals. The County sees the need to bring in

non-law enforcement professionals and paraprofessionals in the settings to assist with meeting the unique and special needs of clients with mental health concerns such as a non-disruptive and safe environment, medications, security, professional intervention, support, housing, in the least restrictive and most appropriate setting. The County reports the FRI is their first step in deciding what intervention is most suitable in considering the consumer's request and need for voluntary assistance.

The County also intends to create a short-term, supportive drop-in urgent care center designed to allow the FRI team to transport consumers, who are not stable enough to remain where they are, but also do not need emergency room services.

The Response

It appears the County will be expanding their current SB 82 triage program to include non-law enforcement first responders such as emergency departments, paramedics/fire/EMS, dispatch, and CIP homeless outreach workers. It also appears they will be using the project to create a Mental Health Urgent Care center, which will be co-located with a community-based drop-in navigation center, to provide an alternate location to transport an individual in a crisis rather than a hospital or jail.

It appears the County seeks to set up a similar collaborative team consisting of mental health professionals and non-law enforcement first responders proactively identifying high, recurrent-use clients and share plans and resources to deter the individuals from hospital emergency departments and jails. The County may also wish to discuss if they considered CHFFA funds and SB 82/Triage funds to develop these two program as seen in other counties with new triage programs for non-law enforcement first responders and urgent centers to divert individuals in a crisis.

As per Section 3930 (4)(C) in the Innovation Regulations, the County may wish to provide the estimated number of clients expected to be served annually and draw an analysis of the cost per client in developing the budgetary formula.

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.

Yolo County incorporated developing this Innovation concept with their stakeholders in conjunction with the submission of their 2017-2020 MHSA Three-Year Plan.

Yolo County reports conducted an extensive outreach effort utilizing a multitude of client-centered materials (also made available in Spanish), activities, phone calls, announcements, and a summit. The County states these efforts resulted in widespread stakeholder interest, participation, and involvement. The County reports participants included: homeless, LGBTQ, TAY, older adults, consumers and family members, peer

support workers, county staff, mental health providers, law enforcement, veterans, and multiple service agencies.

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 seeks to learn if developing mental health and non-law enforcement first responders integrated teams to deploy for mental health crisis calls will significantly impact the consumers, reduce law enforcement intervention rates and calls, decrease hospitalizations, decrease arrests, and ultimately improve wellness and recovery for consumers in a crisis. The County also seeks to improve non-law enforcement first responders' knowledge, skills, interactions, development, and abilities to support mental health clients experiencing a crisis. The County hopes the project will contribute to developing best practices, policy improvements, or procedural changes.

Measurements will be pre- and post-mixed methods consisting of process and outcome indicators. The County will collect and analyze data from baseline studies, consumer wellness surveys, service utilization records, hospitalization and emergency department records, sheriff's records, and jail/incarceration records. Most notably, the plan calls for engaging a wide variety of diverse stakeholders to design and implement a FRI evaluation. The stakeholders will have opportunities to provide experiential feedback.

The Budget

The total budget for the FRI is $4,802,029. Yolo County is seeking approval to use $1,725,139 of MHSA Innovation fund, with the remaining $3,076,890 coming from Federal Financial Participation, and other funding.

The County has provided a budget narrative and chart that includes the total budget for personnel costs, operating costs, and consultant costs. They indicate hiring 4.0 FTE Clinicians, 3.0 FTE case managers, and 0.25 FTE Analyst to build out their new MDTs. They also indicate contracting out 4.0 FTE nurse practitioners to local hospitals and contracting out evaluation to an independent contractor. They may wish to indicate what part of the total personnel costs, operating costs, and consultant costs will MHSA Innovation funds cover.

The project's Innovation budget is broken down into $225,514 for administration (13% if the total MHSA Innovation budget) and $105,000 for evaluation (~6% of the total MHSA Innovation budget or ~2% of the total project budget).

Additional Regulatory Requirements

The proposed project appears to meet the minimum regulatory requirements as stated in MHSA Innovation regulations.

References

AGT. #14-405 Investment in Mental Health Wellness Grant Program Fresno County 1/22/2014;http://www2.co.fresno.ca.us/0110a/Questys_Agenda/MG212654/AS212685/AS212702/AI212837/DO212840/DO_212840.PDF

http://www.sonoma-county.org/health/services/mentalhealthcrisis/asp

First Responders Initiative

Statement of Need

In 2013-14, Yolo County Health and Human Services Agency (HHSA) engaged in a Community Program Planning (CPP) process to develop its MHSA Three-Year Program and Expenditure Plan for 2014-2017. As a part of the planning process, stakeholders identified gaps in the crisis continuum of care as a critical need. To address this need, HHSA applied for and received Mental Health Services Act Oversight and Accountability Commission (MHSOAC) Triage Grant funding to develop the Crisis Intervention Program (CIP) that provides clinical staff to respond to mental health crises in partnership with five law enforcement agencies in the County. The CIP program has been successful in 1) avoiding unnecessary Emergency Department (ED) and psychiatric hospitalization for persons served, and 2) building LEA capacity to respond to mental health emergencies and increasing collaboration between HHSA and LEAs.

During this most recent CPP process to develop the MHSA Three-Year Program and Expenditure Plan for 2017-2020, stakeholders acknowledged CIP's successes and identified the need to 1) expand the collaboration and capacity beyond LEAs to address mental health crises and 2) develop alternative drop-off locations for people who do not need emergency intervention but are too acute to remain where they are.

Proposed INN Project

As such, HHSA and stakeholders developed the First Responders Initiative (FRI), which seeks to:

- Improve collaboration and information sharing between non-law enforcement first responders, other service providers, and consumers;
- Strengthen the shared ability of first responders to address immediate needs and divert people who do not require an involuntary hold or incarceration to another alternative space; and
- Provide a safe, supportive location for consumers when experiencing a crisis too acute to remain in the community, yet not acute enough to require hospitalization.

The FRI responds to these needs by creating two complimentary services and participation in a Health Information Exchange (HIE) to facilitate real-time data sharing. First, the FRI modifies the forensic multidisciplinary team (MDFT) model currently used in other California counties and abroad to integrate non-law enforcement first responders such as EDs, EMS/paramedics/fire, dispatch, and CIP homeless outreach staff into a multidisciplinary team. Second, the FRI establishes a Mental Health Urgent Care center, which may be co-located with a community-based drop-in navigation center, to provide a new alternative for consumers in crisis in Yolo County. The MHUC provides a safe space to meet the immediate stabilization needs of consumers while also providing opportunities for linkages to further services after the immediate incident has resolved.

Multidisciplinary Forensic Team (MDFT)

HHSA plans to modify the existing MDFT practice that exists in other California counties of facilitating a regular, ongoing case conference between LEAs and behavioral health staff to include all first responders (i.e. EMS, EDs, and fire). The purpose of the modified MDFT is to gather all emergency personnel who may encounter someone experiencing a mental health crisis with HHSA and contracted providers to develop a coordinated response for individuals who are likely to come into contact with first responders or have a history of repeated contact.

Mental Health Urgent Care (MHUC)

Currently, LEAs and other first responders only have one option for people experiencing crisis who cannot remain where they are, which is transportation to the ED. HHSA has explored the feasibility of a Crisis Stabilization Unit (CSU), but has determined that the County is too small to support a 24/7 CSU. Instead, the County has designed a MHUC program that can provide crisis intervention services to individuals and their families who do not meet criteria for a 5150 hold but require additional support. This also provides an additional location for first repsonders to drop off someone in need of mental health support; the facility also plans to accept walk-ins and family members dropping someone off, thereby providing an alternative to the ED for consumers and their families. The MHUC services represent a significant expansion of service scope and availability for the consumer population, who previously relied heavily upon the Crisis Intervention Program (CIP) for community-based intervention. Though highly valuable, the CIP is more limited in service hours than the FRI and is subject to participating agency availability, and the only options available for CIP responders are to transport consumers to the hospital or leave them where they are. The MHUC represents a third option for providing support to consumers and would operate 10-16 hours per day, 7 days per week. The MHUC will provide assessment, crisis intervention counseling, peer support, medication support, groups and recovery-based activities, and discharge planning, including linkages and referrals to mental health and other psychosocial supports.

Health Information Exchange

HHSA and the EDs each maintain their own Electronic Health Records (EHRs), and each of the LEAs and first responder agencies maintain separate dispatch and call records. In order to support a coordinated response for people with frequent contact with first responders, EDs, and HHSA crisis and other behavioral health services, HHSA and partners have identified a need to support health information sharing. Recognizing that this is a significant investment of time and resources, HHSA has reached out to the ED partners and health plans to begin the process of including this project as a part of a larger HIE initiative, currently underway.

Learning and Evaluation

To this end, Yolo County is interested in learning how the MDFT, MHUC, and HIE components and the First Responders Initiative (FRI) deepen shared understanding of the extent to which the FRI:

1. Reduces the avoidable use of ED, hospital, and jail admissions for people with serioue mental illness,
2. Increases access to planned and ongoing mental health services following a crisis event,
3. Promotes wellness and recovery for people experiencing a mental health crisis, and
4. Promotes and strengthens collaboration amongst HHSA, behavioral health providers, and first responders (i.e. LEAs, EMS, EDs, and fire) as well as between consumers and providers.

Mixed methods evaluation activities will aim to address the key learning questions of the project and include process and outcome measures that meet INN statuatory requirements.

The following table outlines the data to be collected (i.e., process measures and outcome measures) and potential data sources listed by their respective key learning question (**Error! Reference source not found.**).

Table 1. First Responders Initiative INN Project Evaluation Questions and Outcomes

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
1. Does utilizing the FRI lead to decreased hospital admissions and arrests related to first response situations?	• MDT participation • # of hospital admissions • # of arrests • # of mental health urgent care visits	• # of closed encounters without removal from the community • # of closed encounters with transport to the mental health urgent care • # of closed encounters with hospital or arrest outcome • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA utilization data • Sheriff's Office incarceration records • Hospitalization and ED records
2. Does utilizing the FRI lead to increased non-hospital service access and utilization following a first response situation?	• # of non-hospital services referred during FR encounter • # of referred services utilized following FR encounter • # of non-hospital services referred at MHUC • # of referred services utilized following MHUC	• Service receipt by FRI users following encounter • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA service utilization data

3. How will implementation of the FRI increase the wellness and recovery of participating consumers?	• # of hospital admissions • # of arrests • # of mental health urgent care visits • # of consumers participating in follow-up MH services • # consumers with WRAP	• Consumer experience of care • Consumer perceptions of wellness/recovery	• FRI usage data • FRI referral data • HHSA utilization data • Consumer survey • Consumer focus groups
4. How does FRI implementation contribute to improved collaboration 1) between providers, and 2) between consumers and their providers?	• # of MDT meetings attended by non-LE first responder members • # of MDT meetings integrating non-LE first responders	• Awareness of appropriate services for non-LE first responders • Increased stakeholder perceptions of system-wide collaboration • Consumer perception of collaboration with first responders	• FRI usage data • FRI tool data • Collaboration survey • Focus groups/interviews with MDFT members • Focus Groups with consumers, families, and staff

Community Investments

This project is a collaborative public and private partnership that respresents a commitment amongst all participating agencies as well as the County, HHSA, and stakeholders to continuously improve crisis services, promote collaboration, and ensure that Yolo County residents have access to coordinated, quality services during and following a crisis event. The budget information reflects a significant financial investment of other funds.

AGENDA ITEM 9

Information

July 27, 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 two Subcommittee on Innovation meetings held in July 2017 and next steps for future Subcommittee meetings and projects.

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

Enclosures: Subcommittee on Innovation Brief

Handouts: None

Recommended Action: Information item only

MENTAL HEALTH OVERSIGHT AND ACCOUNTABILITY COMMISSION

SUBCOMMITTEE ON INNOVATION BRIEF

INTRODUCTION

The Mental Health Services Act (MHSA) was intended to drive transformational change for California's mental health system. The Innovation component of the MHSA requires California's counties to innovate to improve outcomes for people with mental health needs.

The MHSA charged the Mental Health Services Oversight and Accountability Commission (MHSOAC) with overseeing California's mental health system, including the MHSA Innovation requirement. To support counties' innovative efforts, and improve opportunities for transformational change, the Commission is working to bring together county leaders, health care providers, consumers and family members, other mental health stakeholders, and representatives of California's innovative sectors, to improve opportunities for Innovation.

As part of this effort, the Commission established a Subcommittee on Innovation. The Subcommittee held its first meeting on May 24, 2017 to listen and engage with counties and others on strategies to support innovation. This brief provides a summary of the meeting, highlighting themes, challenges, and potential strategies discussed by meeting participants and Subcommittee members.

SUBCOMMITTEE MEETING

Subcommittee Vice-Chair Itai Danovitch began the May 24th meeting by introducing the idea that the vision of the MHSA is to "provide the right care at the right time and the right place for at risk families and children" and that this is an audacious goal for the MHSA. He acknowledged how California is rich with resources and the MHSA is one mechanism to support the statewide vision. Subcommittee Chair John Boyd guided the conversation to hear from counties and stakeholders on how Innovation could be the MHSA component leading this charge and how can the Subcommittee on Innovation support the Commission, counties, consumers/family members, and other stakeholders in achieving the potential of MHSA Innovation.

Emerging themes, challenges, and potential strategies

Participants identified numerous challenges and a shared desire to improve opportunities for Innovation.

- **Theme:** Innovation thrives in creativity, takes risks, tests new ideas, and can be disruptive- all for the potential to improve outcomes.
    - *Challenge*: Meeting participants stated that their local government and stakeholders are generally averse to risk-taking. Counties face bureaucratic, fiscal, and cultural challenges that block opportunities to be more creative when developing Innovative project ideas. Counties experience local fiscal and social pressure to focus on easily attainable goals providing direct services as an

outcome. Meeting participants discussed how reaching for riskier goals with uncertain prospects for success, including conducting research or testing protocols, is not easily supported.

- Potential strategies: The Commission should partner with counties, local government, consumers/family members, and other stakeholders to:
  - ✓ Reinforce for local officials, community members, and stakeholders the value of riskier goals when creating local Innovative projects.
  - ✓ Translate the use of testing and research in academia and healthcare in order to apply it to the public mental health system.
  - ✓ Set aspirational goals and create a navigable path to achieve these goals.
  - ✓ Develop strategies to achieve success in Innovation project design.

- **Theme:** Innovation can flourish at many different levels and does not always have to be something never been done before by others.
  - *Challenge*: Meeting participants stated it is unclear "what is considered innovative" and the shared perception that adaptations are less favored by the Commission.
  - Potential strategies: The Commission should partner with counties, local government, consumers/family members, and other stakeholders to:
    - ✓ Establish a shared understanding of the different levels of achievable Innovative projects.
    - ✓ Develop guidance on how to adapt a best practice and still meet the requirements for the MHSA Innovation component based on the Act and regulations.

- **Theme:** Dissemination and learning are essential in Innovation.
  - *Challenge:* Meeting participants stated there is limited sharing of new project ideas across counties during the development stage to support collaboration and reduce similarities in ideas.
  - *Challenge:* Meeting participants shared there is not enough dissemination of lessons learned or ideas that did not succeed. Counties shared the perception that failing is a negative outcome amongst stakeholders and local government.
  - Potential strategies: The Commission should partner with counties, local government, consumers/family members, and other stakeholders to:
    - ✓ Develop opportunities to brainstorm and collaborate on Innovative project ideas through a statewide learning community.
    - ✓ Identify and educate others on the potential long-term impact and learning opportunities from taking risks and "failing" in Innovation.
    - ✓ Capture and disseminate lessons learned from previous Innovative projects to create opportunities to learn and develop improved ideas.

NEXT STEPS

At the first meeting, the Subcommittee members acknowledged gathering valuable feedback in support of identifying achievable and practical statewide strategies to shift the perspective of the MHSA Innovation component across the state. The participants also demonstrated an active interest in working collaboratively to identify these strategies. The Subcommittee members shared their commitment to work with stakeholders to develop short- and long-term strategies to create the learning community for the MHSA Innovation component.

The Subcommittee members commented recognizing the need to embark upon immediate opportunities to collaborate with counties, consumers/family members, and other stakeholders to clarify and provide guidance as counties continue to move forward with developing Innovation plans within their communities. The Subcommittee members heard a need to consider the following strategies to reduce some of the barriers discussed at the first meeting:

1. Establish a framework focused on the process of Innovation project design that counties can use to open up conversations with local stakeholders and government officials.
2. Revise the optional Innovation template to reflect the framework of Innovation.
3. Provide more clarity on requirements based on the Act and regulations to present to the Commission.
4. Identify ways Subcommittee members can engage in direct technical assistance and advisory support to counties prior to presenting to the Commission.

The Subcommittee members will consider spending the next two meetings to refine and adopt a few strategies to address some of the barriers discussed and will continue to hold future meetings to further build upon the framework of Innovation and additional strategies to achieve success in Innovation. The Subcommittee members will continue to provide updates on the planning of the statewide Innovation Summit, tentatively scheduled for Fall of 2017.

AGENDA ITEM 10

Information

July 27, 2017 Commission Meeting

Executive Director Report

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

Presenter: Toby Ewing, Executive Director

Enclosures: (1) Motions summary from the May 25, 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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
May 25, 2017

Motion #: 1

Date: May 25, 2017

Time: 9:22AM

Text of Motion:

The Commission approves the April 27, 2017 Meeting Minutes.

Commissioner making motion: Van Horn
Commissioner seconding motion: Poaster

Motion carried 7 yes, 0 no, and 2 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	☒	☐	☐

Motion #: 2

Date: May 25, 2017

Time: 9:58AM

Text of 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.

Commissioner making motion: Brown
Commissioner seconding motion: Ashbeck

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	☒	☐	☐

Motion #: 3

Date: May 25, 2017

Time: 10:11AM

Text of 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.

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

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

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

Motion #: 4

Date: May 25, 2017

Time: 12:04PM

Text of Motion:

The MHSOAC approves Amador County's Innovation Projects as follow:

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) Years

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

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

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

Motion #: 5

Date: May 25, 2017

Time: 1:05PM

Text of Motion:

The MHSOAC approves Ventura County's Innovation Project as presented, with the intent that the federal drawdown funding will return to the Innovation fund, as follows:

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

Commissioner making motion: Ashbeck
Commissioner seconding motion: Van Horn

Motion failed 3 yes, 5 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	☒	☐	☐

Motion #: 6

Date: May 25, 2017

Time: 1:10PM

Text of Motion:

The MHSOAC approves Ventura County's Innovation Project as presented, reflecting the budget that was presented, as follows:

Name: Children's Accelerated Access to Treatment and Services (CAATS)
Total Project Amount: $2,670,777 of which $1,471,668 is Innovation funds
Project Length: Three (3) Years

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

Motion carried 7 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	☒	☐	☐

Motion #: 7

Date: May 25, 2017

Time: 3:40PM

Text of Motion:

The MHSOAC approves San Diego County's Innovation Projects as follow:

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

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

Motion carried 5 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	☒	☐	☐

Motion #: 8

Date: May 25, 2017

Time: 3:41PM

Text of Motion:

The MHSOAC approves San Diego County's Innovation Projects as follow:

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

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

Motion carried 5 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	☒	☐	☐

Motion #: 9
Date: May 25, 2017

Time: 3:42PM

Text of Motion:

The MHSOAC approves San Diego County's Innovation Projects as follow:

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

Commissioner making motion: Poaster
Commissioner seconding motion: Mitchell

Motion carried 5 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	☐	☒	☐

AGENDA ITEM

Information

July 27, 2017 Commission Meeting

MHSOAC Evaluation Dashboard

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

Changes/Updates:

External Evaluation Contracts

- **Full Service Partnership (FSP) Classification Project** *Mental Health Data Alliance*
  Update: Deliverable 9 is complete.

- **Early Psychosis Evaluation** *The Regents of the Univ. of California, University of California, Davis*
  Update: All deliverables are complete.

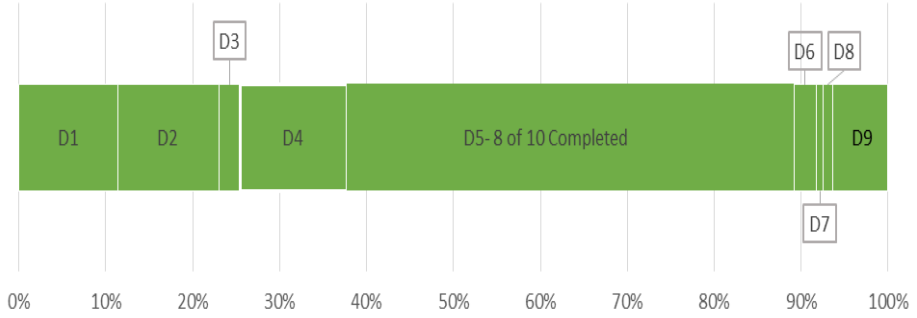
- **Assessment of System of Care for Older Adults** *The Regents of the Univ. of California, University of California, Los Angeles*
  Update: Deliverable 4 is complete.

Enclosures: MHSOAC Evaluation Dashboard
Recommended Action: None
Presenter: None
Motion: None

Snapshot of Contract Deliverables

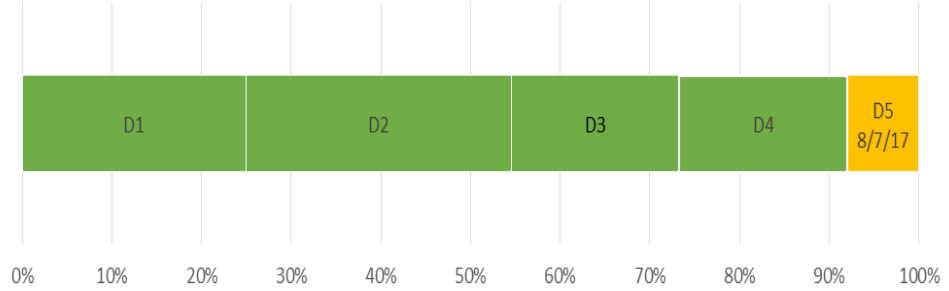
FSP Classification Project
November 2014- June 30, 2017

Assess Full Service Partnerships on a statewide level to enable clients, family members, providers, counties, and the State to further understand the diversity of FSPs across California. (*Contract Amount: $462,313*)



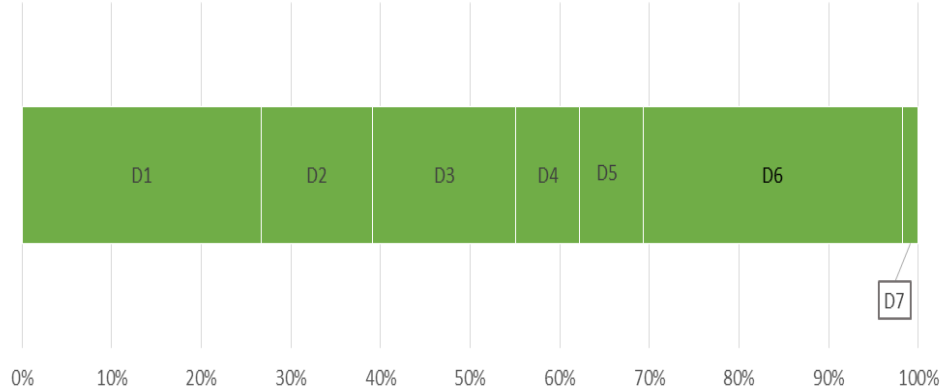
Assessment of the System of Care for Older Adults
June 1, 2015 - August 31, 2017

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



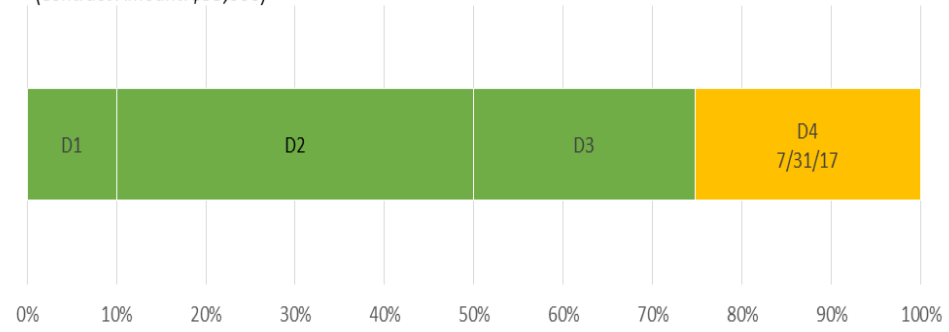
Early Psychosis Evaluation
June 1, 2015 - June 30, 2017

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



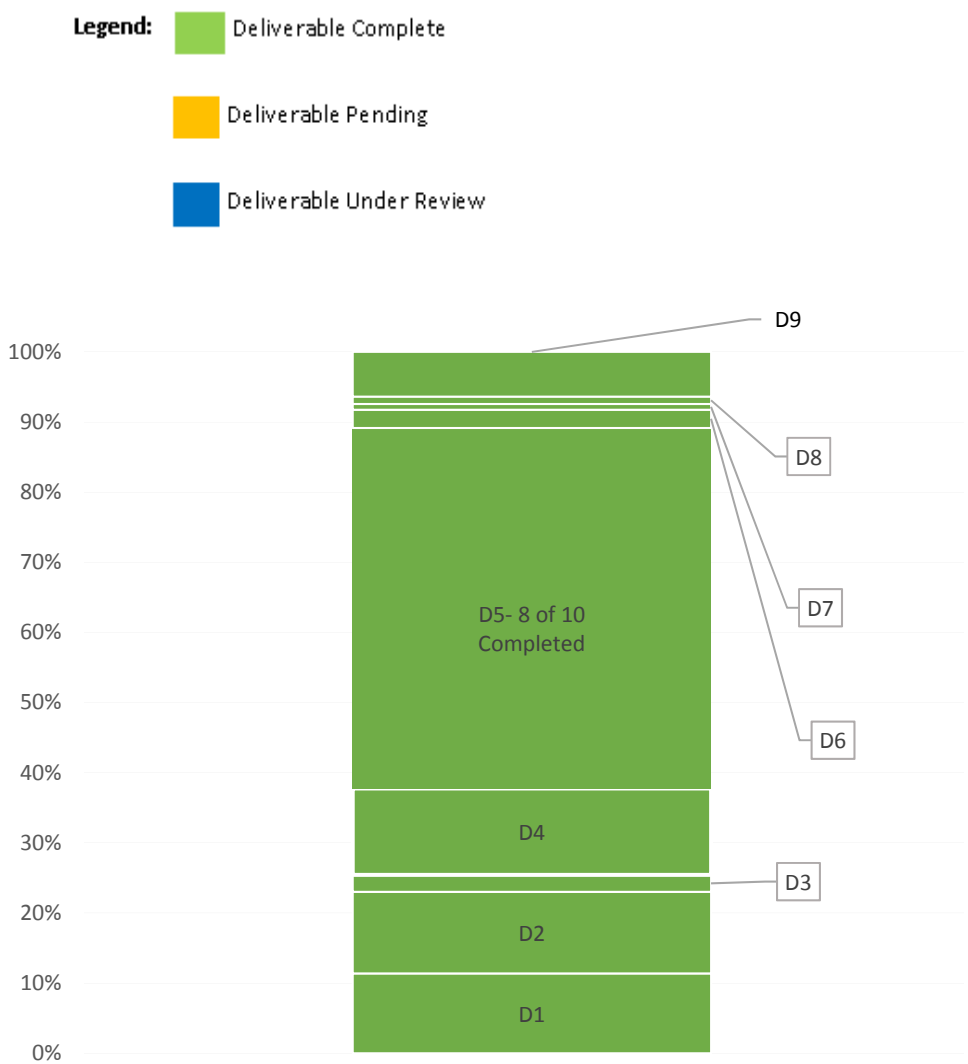
Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit
August 15, 2016 - August 14, 2017

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



Legend: Deliverable Complete Deliverable Pending Deliverable Under Review

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



Full Service Partnership (FSP) Classification Project

November 2014- June 30, 2017

Enable the public and State to further understand statewide assessment of diverse FSPs. A portion of this contract was amended to provide support for implementation of a broader MHSOAC data transparency.
(Contract Amount: $462,313)

Deliverable

D1- Focus Group and/or Interview presentation of FSP Classification System

Status: *Complete*

D2- Stakeholder Input Report of FSP Classification System

Status: *Complete*

D3- Public Comment Report of final FSP Classification System

Status: *Complete*

D4- Report of Online FSP Classification System Website

Status: *Complete*

D5- MHSOAC Monthly Progress Reports (10)

Status: *8 of 10 Complete*

D6- Fiscal Transparency Component Acceptance Support

Status: *Complete*

D7- NAMI—Data Addition for Program Addresses

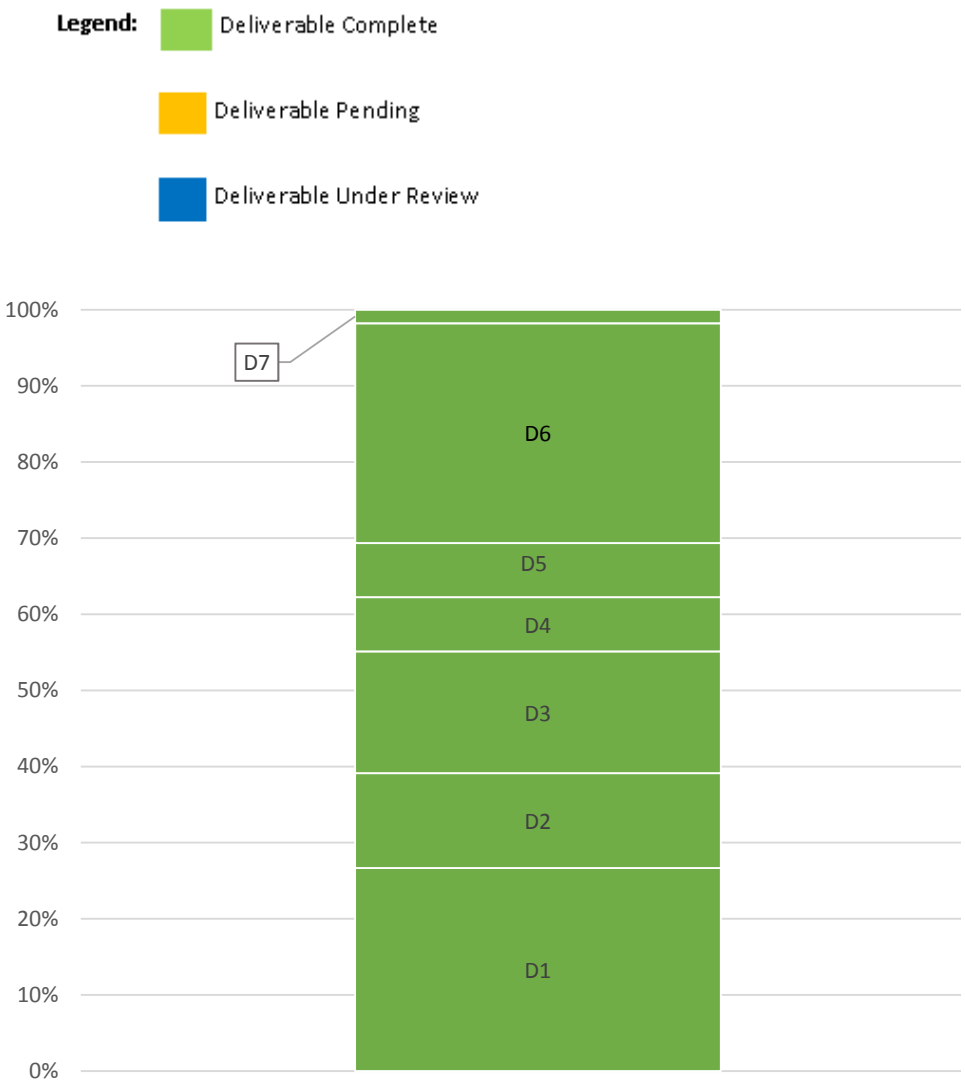
Status: *Complete*

D8- NAMI—Data Addition for Program Providers

Status: *Complete*

D9- NAMI—Data Addition for Three Year Plan and Annual Update

Status: *Complete*



Early Psychosis Evaluation

June 1, 2015 - June 30, 2017

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

Deliverable

D1- Summary Report of Assessment of SacEDAPT Early Psychosis Program

Status: *Complete*

D2- Program Analysis of Costs, Outcomes, & Changes in Methodology Proposal

Status: *Complete*

D3- Report of Research Findings from Sacramento County Pilot

Status: *Complete*

D4- Complete Proposed Plan to Assess Statewide Early Psychosis Programs

Status: *Complete*

D5- Summary Report of Assessment of Statewide Early Psychosis Programs

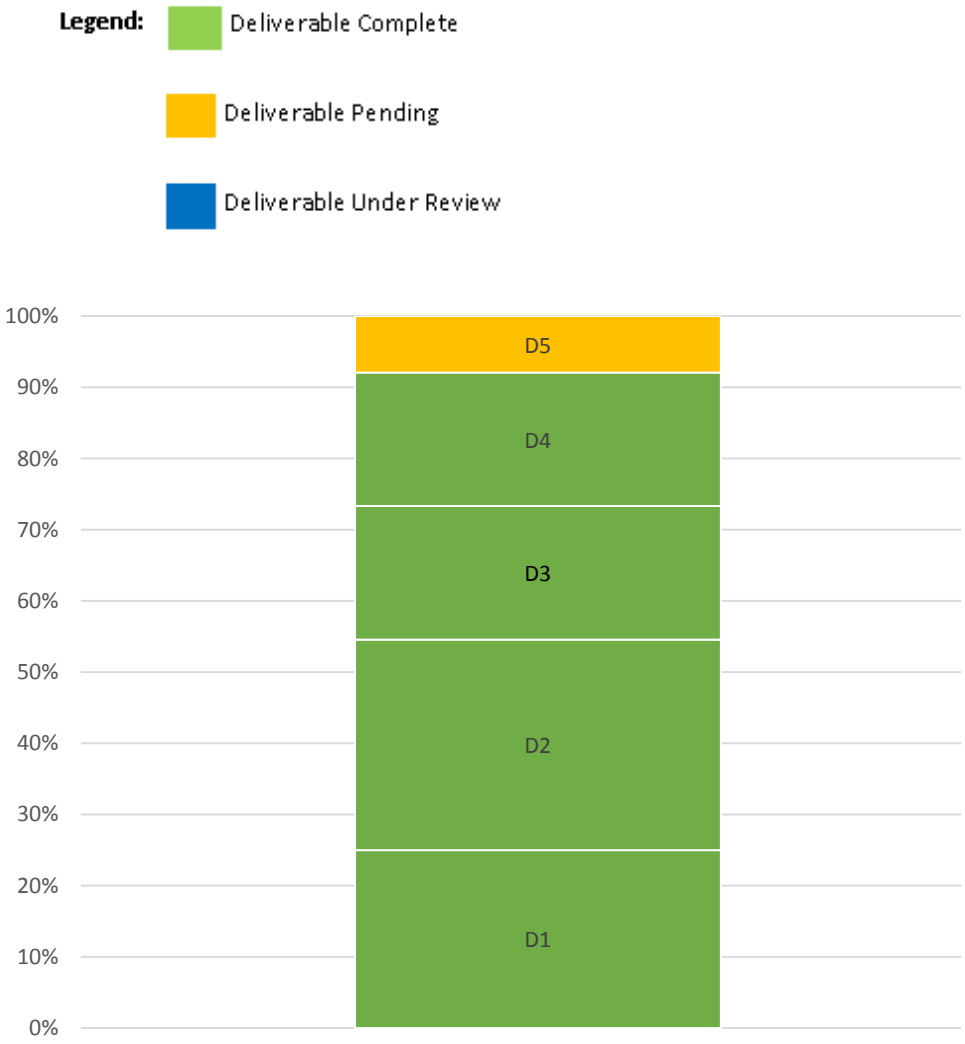
Status: *Complete*

D6- Pilot Study Results & Recommendations for Measuring DUP & DUMI Report

Status: *Complete*

D7- Proposed Statewide Evaluation Plan

Status: *Complete*



Assessment of the System of Care for Older Adults

June 1, 2015 - August 31, 2017

Assess statewide programs by identifying successful methods & implementation of care system for older adults with serious mental illness.
(Contract Amount: $400,000)

Deliverable

D1- Proposed Research Methods

Status: *Complete*

D2- Recommended Data Elements, Indicators, and Policy Recommendations

Status: *Complete*

D3- Summary and Analysis of Secondary & Key Informant Interview Data

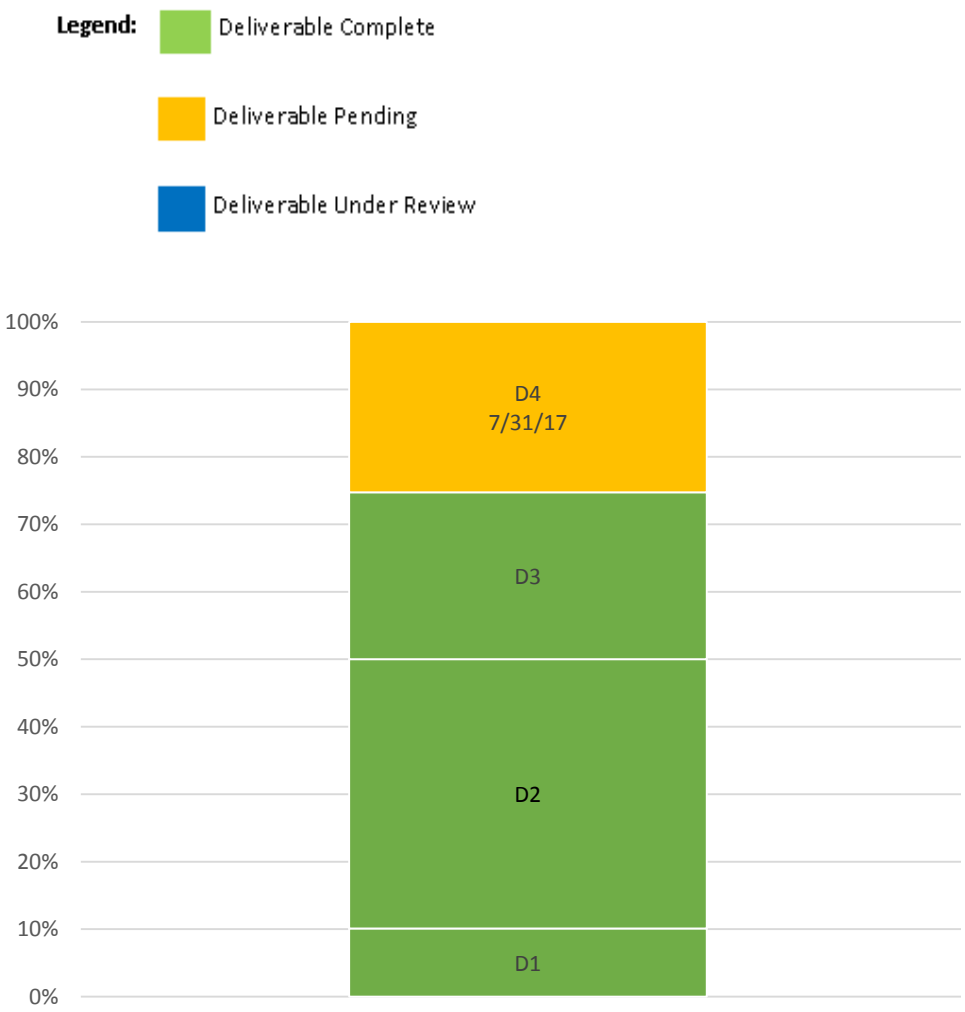
Status: *Complete*

D4- Summary of Focus Group Data and Policy Recommendations

Status: *Complete*

D5- Policy Brief & Fact Sheet(s)

Status: *Pending*



Community Services and Supports (CSS)

Tracking, Monitoring, and Evaluation System Toolkit

August 15, 2016 - August 14, 2017

Assess the feasibility of adopting & implementing CSS Tracking, Monitoring, & Evaluation System to help mental health professionals determine whether clients are in appropriate services by understanding the clinical & functional status of clients within individual CSS programs/services.
(*Contract Amount: $99,000)*

Deliverable

D1- Work Plan

Status: *Complete*

D2- Draft County Toolkit

Status: *Complete*

D3- Regional Meetings Report

Status: *Complete*

D4- Final County Toolkit & Report on Recommendations for Implementation

Status: *Pending*

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, August 24, 2017 Sacramento	**Commission Meeting** TBD
Thursday, September 28, 2017 Sacramento	**Commission Meeting** TBD
Thursday, October 26, 2017 Sacramento	**Commission Meeting** TBD
Thursday, November 16, 2017 Sacramento	**Commission Meeting** TBD
Thursday, December 28, 2017 No Meeting	**Commission Meeting** TBD
rev 07/20/2017	

Mental Health Services
Oversight & Accountability Commission

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