WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
September 26-27, 2018

Hyatt Regency Los Angeles
6225 West Century Blvd
Los Angeles, CA 90045

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplen
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

September 26, 2018
9:00 AM – 4:30 PM

September 27, 2018
9:00 AM – 4:00 PM

Hyatt Regency Los Angeles
6225 West Century Blvd
Los Angeles, CA 90045

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

Public Notice

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

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

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

John Boyd, Psy.D.
Chair

AGENDA

Khatera Aslami-Tamplen
Vice Chair

DAY 1
September 26, 2018

Approximate Times

9:00 AM **Convene and Welcome**
Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission Strategic Planning Session. Roll call will be taken.

9:05 AM **Strategic Planning Session Overview**
Toby Ewing, Ph.D., Executive Director, will provide background on the process and goals of the guided discussion to create a Strategic Plan. Filomena Yeroshek, Chief Counsel, will provide an overview of the Bagley-Keene Act as it relates to the strategic planning process.

9:20 AM **Strategic Planning Session**
The Commission will engage in an initial facilitated strategic planning discussion about the role of the Commission, and the goals and objectives of the Strategic Plan which will be developed through the strategic planning process led by Susan Brutschy, President of Applied Survey Research.

12:00 PM **Lunch Break**

1:00 PM **Strategic Planning Workshop**
The Commission and public will engage in a strategic planning workshop facilitated by Susan Brutschy, President of Applied Survey Research.

4:15 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

4:30 PM **Recess**
The meeting will be in recess until Day 2, September 27, 2018, at 9:00 AM.

DAY 2
September 27, 2018

Approximate Times

9:00 AM **Welcome**

Chair John Boyd, Psy.D., will provide an overview of the outcomes from Day 1 of the Commission meeting - Strategic Planning Session, and will introduce the Transition Age Youth representative, Amanda Southworth.

9:15 AM **Consumer/Family Voice**

Cameron Stout will open the Commission meeting with a story of recovery and resilience.

9:35 AM **Action**

1: Approve August 23, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the August 23, 2018 meeting.

- Public Comment
- Vote

9:40 AM **Action**

2: Kings County Innovation Plan

Presenters:

- Ahmad Bahrami, MBA, Program Manager, Kings County
- Unchong Parry, MPA, Deputy Director, Kings County
- Katie Arnst, MA, Deputy Director, Kings County

The Commission will consider approval of $1,663,631 to support the Multiple–Organization Shared Telepsychiatry (MOST) Project for Kings County.

- Public Comment
- Vote

10:20 AM **Action**

3: Los Angeles County Innovation Plans (2)

Presenters for Conservatees Living in the Community Project:

- Debbie Innes-Gomberg; Deputy Director, Los Angeles County
- Maurnie Edwards, Health Program Analyst, Los Angeles County
- Connie Draxler, Los Angeles Public Guardian
- Evelio Franco, Team Supervisor, Los Angeles County

Presenters for Therapeutic Transport Project:

- Debbie Innes-Gomberg; Deputy Director, Los Angeles County
- Anthony Ruffin, Outreach Worker, Los Angeles County
- Paul Stansbury, Family Member

The Commission will consider approval of (1) $16,282,502 to support the Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community Innovation Project, and (2) $18,342,400 to support the Therapeutic Transportation Innovation Project for Los Angeles County.

- Public Comment
- Vote

12:00 PM **Lunch Break**

1:00 PM **Information**

4: Executive Director Report Out

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

Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

Enclosures (7): (1) The Motions Summary from the August 23, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard (4) Presentation Guidelines; (5) Calendar of Commission activities; (6) Department of Health Care Services Revenue and Expenditure Reports status update; (7) Legislative Report to the Commission.

- Public Comment

1:20 PM **Action**

5: Santa Barbara County Innovation Plan Extension

Presenters:

- Lindsay Walter, J.D., Deputy Director of Operations and Administration, Santa Barbara County
- Lisa Conn Akoni, MA, Marriage and Family Therapist, Santa Barbara County
- Carissa Phelps, J.D., Santa Barbara County

The Commission will consider approval of $2,600,000 to support the extension of the Santa Barbara County Resiliency Interventions for Sexual Abuse (RISE) Innovation Project previously approved by the Commission in May 2015.

- Public Comment
- Vote

2:00 PM **Action**

6: Technology Suite Collaborative Innovation Project

Presenters:

- Karin Kalk, Tech Suite Project Manager
- Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire
- Imo Momoh, M.P.A., Director, Mental Health Services Act, San Francisco County Department of Public Health
- Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services
- Dara H. Sorkin, PhD Associate Professor Department of Medicine University of California, Irvine

The Commission will consider approval of the following Counties' requests to support the Multi-County Technology Suite Collaborative Innovation Projects:

City of Berkeley	$462,916
Inyo	$448,757
Marin	$1,580,000
Monterey	$2,526,000
Riverside	$25,000,000
San Francisco	$2,273,000
San Mateo	$3,872,167
Santa Barbara	$4,912,852
Tehama	$118,088
Tri-City	$1,674,700

- Public Comment
- Vote

3:20 PM **Action**

7: Naming of the Fellowship Programs

Presenters:

- Norma Pate, Deputy Director
- Rebecca Herzog, Associate Governmental Program Analyst

The Commission will consider nominations for honorary naming of the MHSOAC Mental Health Policy Fellowship Programs.

- Public Comment
- Vote

3:45 PM **General Public Comment**

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

4:00 PM **Adjourn**

Back to Agenda

AGENDA ITEM 1

Action

September 27, 2018 Commission Meeting

Approve August 23, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the August 23, 2018 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) August 23, 2018 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the August 23, 2018 Meeting Minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
August 23, 2018

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

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Senator Jim Beall
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Lynne Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo
Larry Poaster, Ph.D.
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:16 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd reviewed the meeting protocols.

Announcements

Chair Boyd highlighted how the Commission composition has changed over the years. He stated the need to carve out time during Commission meetings for Commissioners to have conversations amongst themselves, especially for new Commissioners to bring their voices more fully into the work of the Commission. He asked Commissioners to think how to best do that along with collectively hearing from stakeholders. He stated that was what led to the successful passage of Proposition 63 and what would move the Commission forward.

Chair Boyd stated the old structure was not necessarily serving the Commission well and gave the example of the definition of a quorum where action may be taken by the Commission throughout the meeting, even if there were only two Commissioners left, as long as a quorum was met at the beginning of the meeting.

In preparation for the September Strategic Planning session, Chair Boyd asked stakeholders and Commissioners to think about the following:

- The role and focus of the Commission in today's environment.
- The role of the Chair, Vice Chair, and Commissioners in governing and having oversight in terms of the work, scale, and support of the Executive Director and staff.
- The role of the mental health infrastructure throughout the state.
- How the Commission should move forward, even with basic things such as structure.
- How to manage the significant constraints on the Commission's meeting time given the breadth of its priorities.
    - Consider two-day meetings? Chair Boyd stated he, for the first time, declined three agenda items because meeting agendas have been too full to support robust dialogue.
- The role and reason for engagement in legislation.
    - How much of the Commission time should be spent in this arena?
    - What should the Commission support or not, if anything?
- The role of existing centers such as University of California, Los Angeles and the University of California, Davis, if the Commission agrees to move forward with an academic-based Innovation Center.
- What does oversight really looks like.
- If the Commission provides value to the counties and what do counties need from the Commission.
- The amount of time that should be spent doing policy papers.
    - What do the policy papers truly result in?
    - Will the Commission issue a report on the statewide child and adolescent acute mental health crisis based on its work on this topic since 2015 or 2016? If not, why?
- What do effective counties think of the work of the Commission?

Chair Boyd stated the need for the Commission to reconnect to the public voice. Commissioners need to have intentional discussions about the roles the Committees have served in the past and how to ensure there is broad dialogue with the stakeholders outside of transactional decision-making.

Chair Boyd invited Commissioners to join him in October in Northern and Southern California in talking to local stakeholders about where the Commission is and what it is doing.

Chair Boyd asked stakeholders to send to staff recommendations and input as it relates to the Commission strategy moving forward.

Commissioner Discussion

Commissioner Anthony stated she appreciated Chair Boyd's comments. She stated one of the most important things mentioned was to include families moving forward and to consider what the public, families, consumers, and former Commissioners have done to move mental health issues and services forward.

Commissioner Danovitch spoke in support of this agenda. He agreed that Commissioners have not had enough time to determine processes and procedures that the Commission could engage in to be effective. He noted that having solid processes does not mean that Commissioners have to agree on everything, but solid processes can help the Commission be more deliberate and effective in its work. He stated taking explicit time to ask those questions to make the Commission more effective will pay dividends in the long run.

Commissioner Beall stated he appreciated the work of Governor Brown to improve mental health services and stabilize the financial condition of the state to do so. During the transition to a new governor, it is important to strategize to give the new governor the Commission's suggestions on the issues to focus on to help promote an assertive, progressive agenda for mental health services in California. Timing is important; now is the right time to do larger-picture strategizing.

Commissioner Mitchell encouraged the Commission to put on the spirit of compassion and fight to be deliberate and intentional with the end goal of being the voice of individuals who need help. She stated the need to put aside personal interests and do the work for another human being.

Commissioner Alvarez stated she heard Chair Boyd mention four overarching goals:

- To review procedures and the way business is conducted.
- To do an assessment of commitments the Commission has made.
- To determine appropriate county input on the role of the Commission to ensure the Commission is serving counties well.
- To review the stakeholder engagement process.
    - Assess the role of Committees and if that is a way to facilitate stakeholder engagement more productively.
    - Include public listening opportunities.

Commissioner Alvarez suggested opportunities for greater input from Commissioners as the Commission heads into the September Strategic Planning session.

Commissioner Gordon stated, relative to the work done with the schools, the Commission is beginning to understand that the schools are a place where not just children but families can be reached much earlier to hopefully head off some of the things that create problems down the line.

Commissioner Gordon agreed with the idea of reaching out to stakeholders. He encouraged Commissioners to do site visits to schools to help understand the things the schools are trying to do. He stated the hope for understanding that the health, education, and transportation systems are one system where all of these things are tied together. There are opportunities to bring systems together and collaborate. He agreed with going out and listening to the voices of the people.

Youth Participation

The Commission made a commitment at the beginning of 2018 to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Chair Boyd asked Peter Elias to introduce himself.

Peter Elias, transition age youth (TAY) representative, Fathers and Families and Trauma Recovery Center, stated he helps youth with issues of homelessness, unemployment, and lack of finances. He stated there are multiple solutions to improve homelessness in Stockton. He gave the example of repurposing the several run-down hotels to serve homeless youth.

New Personnel

Executive Director Toby Ewing introduced Nathan Perez, the new Student Intern for the summer.

Meeting Calendar

The next Commission meeting and Strategic Planning session will be on September 26th and 27th at the Hyatt Regency in Los Angeles. The Commission has contracted with Applied Survey Research to facilitate the conversation with Commissioners and the public for the Strategic Planning session.

ACTION

1: Approve July 26, 2018, MHSOAC Meeting Minutes

Vice Chair Aslami-Tamplen stated the minutes do not reflect that agenda items were taken out of order. Ms. Yeroshek stated there is an explanatory note toward the bottom of page 14.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated the need to ensure individuals know when items were taken out of order or removed from the agenda.

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, Out 4 Mental Health, stated the wrong pronoun was used on page 7. Also the speaker's comment was not correctly captured in the minutes. The speaker had commented that the stakeholder contractors could be effective advocates in the face of the two occurrences that were highlighted at the July meeting where the legislators had caught and redirected funding away from the Commission.

Poshi Walker referred to page 17 about Senate Bill (SB) 1004 and stated the correct comment was that only 40 percent of 18- to 24-year-olds are enrolled in college in California, and, therefore, prioritizing college students would mean that 60 to 70 percent of 18- to 24-year-olds would not be included in those who would be served under that direction.

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

The Commission approves the July 26, 2018, Meeting Minutes as corrected.

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Beall, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

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

ACTION

2: Senate Bill 1004 (Wiener and Moorlach) and Senate Bill 192 (Beall) Update

Presenters:

- Adrienne Shilton, Government Affairs Director, Steinberg Institute
- Greg Cramer, Representative, Senator Beall's Office

Senate Bill 192

Commissioner Beall stated SB 192 is on the Governor's desk and it is anticipated that the bill will be approved. He stated the Senate Mental Health Caucus is currently analyzing the members' mental health bills to see the stage of the legislative process that each bill made it through. The Caucus is also analyzing the recommendations of the Department of Finance (DOF) on these bills because it was noted that the DOF opposes almost every bill that relates to mental health.

Commissioner Beall stated he needed to leave for the 10:00 a.m. legislative session but planned to return to the Commission meeting later in the day. He stated his staff, Gregory Cramer, Policy Consultant, would remain to answer questions.

Senate Bill 1004

Adrienne Shilton, Government Affairs Director, Steinberg Institute, stated Angela Hill, representative from Senator Wiener's Office, also left to attend the 10:00 a.m. legislative session and that she would present the update on SB 1004 in Ms. Hill's absence. Ms. Shilton stated the Steinberg Institute is the proud sponsor of SB 1004. She provided an overview of the bill and summarized changes that had been made since the last Commission meeting, as follows:

- Additional language was added to prioritize seniors and their mental health needs with an emphasis on suicide prevention programming and outreach and engagement to isolated seniors.
- Clarifying language was added that the bill in no way changes the requirements of the local stakeholder process.

Ms. Shilton noted organizations that have now given their support due to these changes. She noted that the bill is currently on the Assembly floor.

Commissioner Questions

Vice Chair Aslami-Tamplen stated that currently 51 percent of Prevention and Early Intervention (PEI) funding goes to children and youth. She stated SB 1004 emphasizes youth in colleges, which does not reflect the needs of the communities being served. She stated her concern that the needs of many youths who do not have access to college will not be addressed under PEI, and will not be reached in communities.

Ms. Shilton stated the importance of looking at the entire framework together of what has been prioritized in SB 1004. Amendments have been made to expand SB 1004 to include youth in high school. There are reams of reports and data that show that the mental health needs of individuals in college are not being met. It is important to note that the bill does not exclude youth who are not in college. She stated a specific priority was added about culturally competent programming. SB 1004 is not just for youth in college; it is for all underserved populations.

Vice Chair Aslami-Tamplen asked about the Commission's role and the DOF's bill analysis that states the Commission reported that this level of workload was absorbable within existing resources. She stated there are several Commission projects that have yet to get the attention required for completion.

Ms. Shilton stated the Steinberg Institute has consulted with Commission staff. She stated, if staff had indicated that this bill would increase the workload to the point that new staff were needed, the Steinberg Institute would have advocated for that through the state budget process. She asked Executive Director Ewing to comment.

Executive Director Ewing stated staff has worked with the Fiscal Committees in both houses to assess what it would cost for the Commission to do the work. The analysis showed it would cost the Commission an estimate of approximately $500,000. The bill would give the Commission the opportunity to put in a request through next year's budget process to receive the funds to do the work required.

Vice Chair Aslami-Tamplen asked if the Commission would be required to do the work if the budget augmentation was not approved. Executive Director Ewing stated the statute states the work is subject to funding. If it is not funded, discussions will ensue about how robust and how quickly the Commission could do the required work.

Vice Chair Aslami-Tamplen asked if the PEI plans will be approved locally or at the state level. Ms. Shilton stated PEI plans will continue to be adopted by the county boards of supervisors.

Commissioner Alvarez stated the response to the first question was amorphous – that everyone is a priority. She asked what the priority is and how it will be operationalized.

Ms. Shilton stated the priorities are intentionally broad. The author is trying to establish a strategic vision and is asking the Commission to lead in that process with stakeholders and counties. She stated it is a balance between prioritizing programs and allowing for local flexibility. The bill does not mandate counties on what to fund, who to partner with, or how much funding to put forward for these programs. The author drew on research and best practices to develop the framework. Part of the implementation role of the Commission would be to operationalize this framework and to update it as new innovations come into the field and establish corresponding metrics, outcomes, and evaluation strategies to track how counties are making impacts with PEI funds.

Ms. Shilton stated one of the concerns is having 58 different strategies for the 58 counties. This bill is trying to scale up what is already known to work. She stated all counties will not fund all five goal areas, but there needs to be a more strategic plan for how funds are governed.

Chair Boyd asked Ms. Yeroshek to restate the motion on this bill that the Commission had passed prior to the July Commission meeting.

Ms. Yeroshek stated, prior to last month's motion, the Commission had supported SB 1004 in concept and had authorized the chair and executive director to continue to work with the author's office regarding refinement of the language.

Chair Boyd stated he has not met with legislative staff or members in regards to any of these bills. He stated the Commission directs Executive Director Ewing to do that and to report back to Commissioners collectively. He clarified that he had no direct engagement with the Legislature or the governor's office on the bills.

Commissioner Mitchell asked who is opposed to the bill and why.

Ms. Shilton stated the DOF submitted a formal opposition because of the costs and the contrast of the local stakeholder process versus the state setting priorities.

Vice Chair Aslami-Tamplen added that the DOF also states there is already a priority through the PEI Regulations.

Public Comment

Bill Floyd, Peer Recovery Art Project and NorCal MHA ACCESS, shared the story about trying to find emergency services for his granddaughter. There were no services available for her because her mental illness was labeled mild to moderate. The speaker asked why an individual must be severely mentally ill to received emergency services under PEI.

Poshi Walker stated the California Behavioral Health Planning Council (CBHPC) also opposes SB 1004. The speaker spoke about the term “priority” when it comes to partnerships with college mental health programs and college students. Only 40 percent of California’s 18- to 24-year-olds are enrolled in college. Only 10 percent of 18- to 24-year-olds are enrolled in UC and state universities and 30 percent are enrolled in community colleges. UC and state universities already provide some type of mental health services and have counselors and other adults as resources. The speaker was deeply concerned about the 60 percent of 18- to 24-year-olds who are not in college. These represent the most disenfranchised and often most vulnerable youth. All youth are at risk for a first occurrence of mental illness. Individuals should not be a priority solely based on their ability to enroll in college. NorCal MHA has met with the author’s office to ask that the word “priority” be removed. The speaker requested that SB 1004 be amended to prioritize all 18- to 24-year-olds before the Commission adds their support to this bill.

Michael Helmick, Senior Policy Analyst, California Health+ Advocates, spoke in support of SB 1004.

Stacie Hiramoto agreed with Poshi Walker’s comments about supporting youth who are not in college. The speaker stated youth with severe mental health challenges in high schools have difficulty getting into college. They should be able to get services, even when not in college. The speaker stated concern about reopening the PEI regulations. REMHDCO has taken a support if amended position to remove the preference for college students.

Samantha Poteet, NorCal MHA, spoke in opposition to SB 1004. 3 million deaf individuals are identified in the state of California and over 90 percent of the deaf community has experienced trauma in their lifetime. The deaf community is 20 years behind in substance abuse and alcohol education. American Sign Language (ASL) is a visual independent language of grammar and syntax and is independent of English, but there is a lack of trained individuals who can sign. 20 percent of the deaf community reads at a second-grade level or lower. The deaf community is a culture rich with history in their language. They are underserved and underrepresented for mental health services.

Sandra Marley, client advocate, did an internship in British Columbia Parliament. The speaker addressed SB 1004 and asked if funds will be provided for extra staff to do the work. When Proposition 63 passed, the voters voted for mental health, not a representative or a senator. Bringing in the Legislature is doing that. The California Constitution is not taught at many colleges because it has gotten too large due to the number of initiatives that were added as amendments to the Constitution.

Sandra Marley addressed SB 192 and stated innovation programs received separate funding for evaluations and nothing has gone to the patient. The County Behavioral Health Directors Association (CBHDA) should not be brought in for regulation because it is a private entity.

Steve Leoni, consumer and advocate, addressed SB 1004 and stated the key point is that it establishes priorities. The Commission has something to do with that – it is not just imposed by the bill. Counties have the right to say they want to do something different. SB 1004 establishes a much-needed dialogue at the county level about strategic thinking. This should be extended beyond PEI. The issue about college youth versus noncollege youth is still outstanding; rewording there would be useful. Overall, the amendments have moved SB 1004 in a better direction.

Steve Leoni addressed SB 192 and stated there is an ambiguity caused by the bill. The prudent reserve must be at 33 percent of the last five years and every five years it gets recertified. There is no provision for the prudent reserve in SB 192 when it goes below 33 percent.

Margot Grant Gould, Policy Director, First5 Association of California, spoke in support of SB 1004.

Kathryn Kietzman, Researcher, University of California, Los Angeles, Center for Health Policy Research, spoke on her own behalf. The speaker appreciated the amendments made to SB 1004 in an attempt to address stakeholder concerns including older adults. The concerns that many stakeholders have expressed about the language and intent of SB 1004 extend far beyond any particular population subgroup. While the latest amendments address specific concerns, they do not address the deeper concern about maintaining the inclusive representative- and stakeholder-driven process, which is the foundational principle of the Mental Health Services Act (MHSA). Priorities identified for PEI programs must reflect those identified through a local and robust stakeholder engagement process, not through priorities identified and established at the state level. Commission time to carry out its existing functions is already constrained. SB 1004 will lead to the allocation of funds to PEI programs that are not fully responsive to local needs and priorities.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, echoed previous comments about the stakeholder process taking place at the county level and being about the needs of the county. The CBHPC has confirmed that they oppose SB 1004 unless amended. The speaker's organization is concerned about prioritizing college students and supports including marginalized individuals and individuals who experience disparities. It is concerning to see a population prioritized based on an achievement they have made. Individuals should be prioritized who have difficulty making those milestones because of their mental health. The speaker suggested prioritizing all TAY.

Noah Hampton-Asmus, NorCal MHA ACCESS, spoke in support of the intentions of SB 1004, but was concerned about the absence of stakeholder involvement in program and policy planning at the state level. The speaker spoke in support of focusing on all 18- to 24-year-olds.

Smitha Gundavajhala, Young Minds Advocacy, reiterated a comment the speaker made at the March meeting that prevention is lifelong. That was reflected in some of the changes made to SB 1004. Earlier today, it was brought up that it was challenging to focus on individual details of what was missing rather than the larger aim of the bill. The speaker stated the aim of this meeting and of the public stakeholder process is to note when there are details where communities have been overlooked that have been historically overlooked because they tend to be overlooked.

Smitha Gundavajhala stated it is telling that the DOF wants to see more of the stakeholder process. This provides an opportunity to reflect on the young people who have been overlooked, in particular TAY who are not in college and high school youth. Because there is no structure in place to reach TAY who are not in college, that makes them all the more important to reach. Every young person or population that gets left behind because they are harder to

reach perpetuates the very inequity that prevention is supposed to capture. The speaker suggested a focus group, advisory council, or stakeholder process that speaks to TAY mental health issues that are not captured in SB 1004.

Dr. Marty Giffin, California Mental Health Advocates for Children and Youth (CMHACY), stated one of the goals of SB 1004 is childhood trauma. A commonly-cited study out of Yale University showed that preschoolers are three times as likely to be expelled as students from kindergarten through 12th grade. Dr. Giffin stated the hope that this goal is expanded upon and that all kindergarteners are screened for adverse childhood experiences (ACEs) or that preschoolers who are showing at-risk behaviors are screened and appropriately supported through the transition from preschool to kindergarten and the primary grades.

Naomi Ramirez, Mental Health Specialist, CBHPC, confirmed that the CBHPC opposes SB 1004. While the council agrees that there is a need for a more transparent system to articulate how PEI funds are spent, members feel that the Commission already has that authority in state law. The speaker echoed the previous comments about leaving it up to counties to set priorities and identifying individuals enrolled in college as the priority.

Commissioner Discussion

Commissioner Mitchell stated she heard a lot from stakeholders about TAY enrolled in college versus TAY in general. It sounds like it is "us versus them," but all youth are important. She suggested prioritizing youth on college campuses as well as all other youth. Individuals cannot be left out because they have not chosen or qualified for college.

Commissioner Anthony agreed with Commissioner Mitchell.

Vice Chair Aslami-Tamplen also agreed with Commissioner Mitchell about being inclusive in terms of TAY. She asked how the PEI regulations will be impacted.

Executive Director Ewing stated the Commission has authority to issue regulations regarding PEI programs. The regulations are designed to bring clarity to the legal requirement. They are a more detailed reflection of the law and are not supposed to move beyond the requirement of the law. There are a number of areas where the MHSA is being modified and the Commission needs to anticipate an ongoing process of revisions to the regulations to reflect the changes in statute over time. The Commission, with some exceptions, has discretion over how and when it does that.

Executive Director Ewing stated the language in SB 1004 is not clear if it will require revisions to the regulations because of the flexibility that it provides counties. The bill tries to find a balance between encouraging statewide strategic investments in key opportunities in prevention with sufficient flexibility for counties that want to deviate from those priorities.

Commissioner Gordon stated the language of SB 1004 is flexible so counties can set their own priorities and approve their own projects. He stated, if TAY who are not enrolled in college are a higher priority than TAY in college, counties will have to pay attention to both and can prioritize however they wanted.

Ms. Shilton agreed that SB 1004 at its core is about leadership and not about micromanaging. It does not take local decisions away from counties.

Chair Boyd asked Gregory Cramer, Policy Consultant, Senator Beall's Office, to comment on SB 192 prior to the Commission vote.

Mr. Cramer stated there was one minor amendment to SB 192 since the last Commission meeting. The previous version of the bill had the maximum amounts of community services and

supports (CSS) that the county can maintain within their prudent reserve as the total amount of revenue received for the fund in the preceding ten years. The bill was amended to replace that with a 33 percent as a cap to be held in the prudent reserve. This is a more transparent and straightforward metric. It calls for counties to reassess these levels every five years.

Mr. Cramer stated SB 192 has moved off of the Assembly and Senate floors and is on its way to the Governor's office. The bill has not received any opposition or "no" votes. He requested that the Commission continue to support SB 192 by submitting a letter of support to the Governor's office.

SB 192

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

The MHSOAC supports Senate Bill 192 (Beall).

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Boyd.

SB 1004

Action: Commissioner Gordon made a motion, seconded by Commissioner Madrigal-Weiss, that:

The MHSOAC supports Senate Bill 1004 (Wiener and Moorlach).

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

The following Commissioners voted "Yes": Commissioners Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Boyd.

The following Commissioner voted "No": Commissioner Anthony.

The following Commissioner abstained: Commissioner Alvarez.

ACTION

3: <u>Monterey County Innovation Plans</u>

Presenters:

- Amie Miller, Psy.D., Behavioral Health Director, Monterey County
- Wesley Schweikhard, MPP, Management Analyst, Monterey County

Amie Miller, Psy.D., Behavioral Health Director, Monterey County, provided an overview, with a slide presentation, of the problem, Innovative components, evaluation, and sustainability of the two Monterey County Innovation Projects.

Wesley Schweikhard, Management Analyst, Monterey County, continued the slide presentation and discussed the learning goals of the two Monterey County Innovation Projects.

Commissioner Questions

<u>Micro-Innovation Grant Activities for Increasing Latino Engagement Innovation Project</u>

Commissioner Mitchell asked if there are many Latinos on the team.

Dr. Miller stated there are. She noted that the workforce has evolved but the client statistics remain at a flat 54 percent Latino.

Commissioner Mitchell suggested ensuring that there are many Latinos there to greet clients to allay fear in that population.

Commissioner Alvarez stated her organization recently conducted a survey of Latino and immigrant families about the national climate and its health impacts on children and families and found similar outcomes of discomfort in seeking services, disenrolling from programs, and staying home from everyday activities. The proposed project would identify new solutions to this problem. Her organization also found that many individuals who support the mental health and wellbeing of immigrant and Latino communities are not necessarily mental health providers or are not connected to the mental health system. She asked how the county will engage nontraditional partners in this work to reach this population, how the county expects this Innovation project to increase the number of Latino clients by 7 percent, and how grantees will be held accountable for outcomes.

Dr. Miller stated the county has a nontraditional network such as *promotores* and senior peer companions to engage community members in discussing mental health. The problem is not enough individuals are referred in. The hope is that the proposed Innovation project will bring individuals to the table who have never been before through creating contracting processes.

Vice Chair Aslami-Tamplen stated one of the challenges faced in Alameda County was getting Latino-focused organizations to apply for grants. She questioned the one-year goal and suggested extending it out.

Dr. Miller stated the idea is to test small ideas for three months, evaluate the outcomes, make improvements, and try it again. These are rolling Innovations that are scaled up so that, in the end, several Innovations will be working simultaneously.

Commissioner Madrigal-Weiss asked how many of the county's four workgroup sessions were conducted in Spanish.

Mr. Schweikhard stated roughly half of the focus groups were conducted in Spanish.

Dr. Miller added that all focus groups had translation available. She noted that the door-to-door surveys were conducted in Spanish.

<u>Transportation Coaching by Wellness Navigators Innovation Project</u>

Commissioner Gordon stated the proposed Innovation project funds navigators to help individuals utilize the existing transportation system. This is a worthwhile project. Part of the statewide problem is that the transportation system is not suited to getting individuals from where they are to where they need to go. He asked if there had been efforts to influence the transportation system.

Dr. Miller stated the county has done things such as contracting with the bus to change its route so it stops closer to clinics. She agreed that the public infrastructure has been a challenge. Multiple strategies need to be invested in.

Commissioner Alvarez stated she recently learned of a similar effort particularly for TAY in Los Angeles with an organization called HopSkipDrive. Talking with them opened her eyes about the importance of transportation. She cautioned that this similar effort was more expensive and in higher demand than expected. She supports the project but thinks there is not enough funds and is concerned about sustainability.

Dr. Miller stated the county believes it will be able to bill MediCal because of the couching.

Public Comment

Kontrena McPheter spoke in support of the proposed projects.

Antonio Garibaldi spoke in support of the proposed transportation project.

Mario Ramirez spoke in support of the proposed projects.

Mandy Taylor suggested the county include a piece in the Request for Proposals (RFP) committed to the MHSA general standards of cultural competence of equal access and addressing disparities, particularly with the queer and trans communities for the Micro-Innovation Grant project.

Hector Ramirez spoke in support of the proposed projects. The speaker is impressed by how Monterey County involves the community in its Innovation project development. The speaker encouraged empowering the peers not only to do the work but to foster advocacy for the individuals that they work with. Advocacy is part of health care.

Noah Hampton-Asmus emphasized the inclusion of peers and navigators in the wellness recovery approach.

Maureen Bauman spoke in support of the proposed projects.

Smitha Gundavajhala spoke in support of the proposed projects.

Sandra Marley questioned the term payment condition on achievement of deliverables and the breakdown of the micro-innovative grant review and suggested a greater breakdown of the budget items.

Steve Leoni spoke in support of the proposed projects.

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

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

Name: Micro-Innovation Grant Activities for Increasing Latino Engagement

Amount: $1,240,000

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

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

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

Name: Transportation Coaching by Wellness Navigators

Amount: $1,234,000

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

INFORMATION

4: Executive Director Report Out

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

Chair Boyd stated that Vice Chair Aslami-Tamplen will work with staff to include multi-Commissioner engagement around agenda setting and a greater public engagement process, which is expected to be in place for the September meeting.

Chair Boyd stated the Overview of Commission Framework document put together by Executive Director Ewing, listing all Commission activities, was distributed to Commissioners for their review.

Executive Director Ewing presented his report as follows:

Fellowship Project

Staff has been working with the Vice Chair to frame out the Fellowship Program for a mental health consumer and a mental health practitioner. The first step is to form an advisory committee. An application to be a part of the advisory committee will be posted on the website next week.

The Commission received a letter from the Steinberg Institute suggesting to name the mental health practitioner fellowship after Rusty Selix, Executive Director, California Council of Community Behavioral Health Agencies (CCCBHA) and Mental Health America of California (MHAC), and the consumer fellowship after Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), Peers Envisioning and Engaging in Recovery (PEERS), and Program Director, Client Stakeholder Project (CSP), in recognition of their many years of leadership in mental health.

Budget Priorities

The state's budget has been finalized. The Commission's operational budget was approved last month. Last month's approval was for non-discretionary spending and did not include approval for discretionary spending. Those contracts will be brought to the Commission for approval. Staff is working toward an activity-based budgeting report to show the Commission where all funding went and what it was dedicated to.

The budget process for next fiscal year is forthcoming. Proposals for new spending priorities need to be addressed in late September.

A recent report from the DOF was included in the meeting packet that gives an accounting of the allocations of the state portion of the MHSA revenues. The MHSA provides for up to 5 percent of MHSA funds for state operations. This is known as the state administrative cap. The DOF report shows approximately $35 million of unallocated state administrative dollars under the MHSA. There will be an interest moving into the budget conversation next year on how to best utilize those dollars. The $12 million budget reduction for triage led to savings rather than the intended outcome of redeployment for higher value uses.

Legislation

The Commission is sponsoring SB 1113, which would authorize the Commission to develop a voluntary standard on workplace mental health. That bill has passed out of the Legislature and is now headed to the Governor's desk. Staff will prepare a letter of support to the governor to ask for his signature.

Triage Grants

The Commission supported modifications to the triage grants last month. Staff is working to put those contracts in place. There is some confusion in the broader mental health community that the Commission is delaying the start date of the grants. Some counties are electing to receive the reduced level of funds and they will modify their projects based on the reduction of funds. Other counties are opting to use their local funds to make up for the gap, but this requires a local planning process, which delays the start date.

Innovation Plan Review and Approval

The Innovation team has done a tremendous job in tracking Innovation plans, streamlining the process, and strengthening the analysis. An Innovation Dashboard is included in the meeting packet.

Innovation Incubator

The conversation on the Innovation Incubator has been set aside to allow staff to engage stakeholders to provide feedback. A modified Innovation Incubator plan will be presented to the Commission at a later date. The Commission received $2.5 million dollars for the Innovation Incubator – these funds must be encumbered by July, the end of the fiscal year, or the Legislature must be asked for an extension to encumber those dollars.

Youth Innovation Project

A proposal for a youth innovation project was distributed to Commissioners at a prior meeting building on a conversation by the Chair last February about focused conversation and engagement around youth and innovation. With support from the Vice Chair, staff engaged youth from northern counties and last week was in the Central Valley. Positive feedback has been received. The project is being modified based on that feedback. The intent is to hire someone to develop a partnership with an organization that can help make this real since staff is at capacity.

Early Psychosis Plus Program

Assembly Bill (AB) 1315 established an early psychosis program that authorizes the Commission to raise private dollars and issue grants to support early psychosis initiatives around the state. The Commission is required to appoint an advisory committee to support the distribution of funds. Part of the challenge is the lack of funding to launch the project. Staff is exploring models around the state where other state agencies have a private foundation to raise private funds for those purposes. There are a number of counties that are interested in expanding or improving their early psychosis work. In coordination with UC Davis, they have asked for a small amount of funding to facilitate a multi-county collaborative. The intent is that a coalition of counties would present an Innovation proposal before the Commission at a future date.

Suicide Prevention Plan

Future meetings on this issue to engage diverse communities will be in Clovis on September 7th and in Alameda County on September 24th and 25th.

Schools and Mental Health

A meeting is scheduled in Oakland on September 7th and in the Central Valley on October 3rd. The Oakland meeting will focus on diverse LGBTQ communities and the Central Valley meeting will focus on the Asian Pacific Islander community. There is also a meeting scheduled in San Diego, which will focus on engaging Latino parents.

Transparency Projects

In addition to the Fiscal Transparency Tool, staff is working to build a second component that shows all programs. It contains data from 50 counties that represent over 1,300 community mental health programs funded with MHSA dollars with the ability to filter by key words.

Strategic Planning

The ten page document distributed to the Commissioners is to start the conversation for the September strategic planning meeting.

Commissioner Alvarez asked if the Commissioners should be prepared to respond to this document at the September meeting.

Executive Director Ewing stated that the document is intended to be a reminder of what the Commission is doing. It is not envisioned as homework.

Commissioner Danovitch stated that the agenda planning process is important and to give any ideas to the Chair or to Commissioner Ashbeck.

Commissioner Discussion

Vice Chair Aslami-Tamplen spoke in favor of having the naming of the fellowship program on the agenda for the Commission's meeting next month.

Commissioner Alvarez asked for a monthly meeting calendar that includes committee and subcommittee meetings.

Commissioner Anthony stated the website does not mention special population outreach for the Suicide Prevention Plan meetings. She asked about individuals who want to attend who do not belong to the focused population. It should be inclusive.

Ashley Mills, Senior Researcher and Project Lead, clarified that the meeting in Fresno on September 7th is a Suicide Prevention Subcommittee meeting and is open to the general public. The meeting on October 24th is a community forum outreaching to diverse communities but anyone is welcome to attend.

Public Comment

Hector Ramirez thanked Toby for all the work the Commission is doing. The speaker stated the Innovation Summit included a discussion about bringing to the Commission the idea of creating a project that would address the unmet needs of migrant, immigrant, and refugee communities. That is an issue that many counties and residents are struggling with. He asked the Commission to spearhead that project to look into how the Commission can guide the state and departments of mental health on how they can better serve and meet the needs of populations that are constantly under threat.

Executive Director Ewing stated the Commission is thrilled to be able to offer approximately $2 million to do advocacy on behalf of the needs of immigrants and refugees. The funds will soon be made available specific to the issues raised.

Sandra Marley asked the Commission to try to get Job Accommodation Network, the federally-funded organization, in for AB 1113. They have a good website that is free and they offer free consulting for workers and employers. SB 688 should not have a nonprofit in there. The speaker asked if they have lived experience for SB 906. The speaker asked if the Commission has enough funds to do the work of SB 1004. AB 1215 has the possibility to do research on the brain. The British Broadcasting Company (BBC) put out a documentary on artificial intelligence and mind control three weeks ago. The speaker recommended watching that program.

LUNCH BREAK

ACTION

5: Santa Clara County Innovation Plan

Presenters:

- Toni Tullys, MPA, Director, Behavioral Health Services, Santa Clara County
- Steve Adelsheim, M.D., Director, Stanford Center for Youth Mental Health and Wellbeing
- Cha See, Ph.D., Program Manager, School Linked Services, Santa Clara County

Toni Tullys, Director, Behavioral Health Services, Santa Clara County, provided an overview, with a slide presentation, of the problem, Innovative components, learning goals, and sustainability of the proposed Innovation project.

Commissioner Questions

Commissioner Danovitch asked how the county is defining the model.

Ms. Tullys stated it will be a site with mental health, substance use, primary care, employment, and education resources driven by a youth advisory group to create a space that is comfortable to come into.

Steve Adelsheim, M.D., Director, Stanford Center for Youth Mental Health and Wellbeing, stated it is a one-stop shop storefront model where young people could come in on their own or with a friend or family member to get mental health interventions integrated with primary care and linkages to other services.

Commissioner Danovitch asked if there was a project plan and what the deliverables were that came out of the ramp-up phase. Evaluating those would help drive the next steps.

Ms. Tullys stated the ramp-up has been focused on what this model will look like in California. The county is overcoming the challenges of how to make headspace into an integrated health care model to deliver on the design elements in such a way that there is flexibility. The roles of each partner were defined and feedback was gathered from youth and community-based organizations.

Cha See, Ph.D., Program Manager, School Linked Services, Santa Clara County, stated one of the objectives during the ramp-up phase was to develop an evaluation plan. The county is in the process of developing goals and objectives with the idea of replicating this model to other counties. One essential piece of the evaluation development is to work with the youth advisory group to make it a community-based effort.

Commissioner Danovitch asked for a copy of the materials/deliverables that were developed during the ramp-up phase mentioned by the presenters.

Commissioner Mitchell stated she liked the big-picture thinking but questioned the two-site model.

Ms. Tullys stated there is a high level of need in the community. The county wanted to create a model to serve the majority of commercially-insured youth in two settings to provide richer information about how to make this model work in different populations throughout the state.

Peter Elias asked about other requirements to participate besides the age range of 18 to 25. Dr. Adelsheim stated anyone can participate.

Vice Chair Aslami-Tamplen hoped to see an increase in peer positions. She asked about the hours that the sites were open and the hours that the youth advisory group recommended.

Ms. Tullys stated the county is starting with four peers and will add more staff as needed.

Dr. See stated the youth advisory group's idea was to have evening and weekend hours.

Commissioner Danovitch stated it sounds like his questions were addressed during the ramp-up phase. There were many experts and stakeholders that were engaged and a lot of thought had gone into it. He stated the need for the Commission to review those materials.

Ms. Tullys stated extensive materials had been submitted to staff.

Chair Boyd asked staff to provide a copy of those materials for Commissioner Danovitch's review.

Commissioner Gordon asked which school districts the county is working with and what they are doing to move this project along.

Dr. See stated the county has a partnership with over 200 schools in 13 school districts out of the 32 school districts in Santa Clara County. The school districts help recruit students to be part of the youth advisory group. The county will continue to work with the school districts to create this public behavioral health continuum of care.

Commissioner Gordon asked how the school districts will know how to get a student to the service. The narrative lacked information on how this would work.

Dr. Adelsheim stated two positions have been created to develop liaison relationships with schools, community colleges, and employment programs across the county, to support young people coming into the sites to help link them back to their schools for support, and to liaison with the schools as a referral person to help link young people to these sites. These positions were funded through the county's General Fund a year and a half ago to help work on the development of these sites.

Commissioner Alvarez asked questions about the headspace model. Chair Boyd asked the presenters to give a high-level overview of the headspace model for the Commissioners who were not present at the prior meeting.

Dr. Adelsheim provided a quick overview of the model and how the county came to this model.

Chair Boyd stated he and Executive Director Ewing had in-depth discussions on this, were shown videos, and had headspace staff from the centers walk them through the ins and outs of the program. The county had delivered their presentation previously to the Commission so the idea in today's meeting was to focus on the project based on all the steps taken to get to this moment. He stated the need for continuity of information will be discussed during the Strategic Planning Session in September to ensure this does not happen again.

Commissioner Danovitch stated it was helpful to review the additional supplemental materials provided by staff. They were not assembled in a way to answer all Commissioner questions but that is not a reflection on the project. He stated the county seems to have done the due diligence the Commission is looking for. He suggested ongoing monitoring or oversight to track the success of this project to ensure it is hitting milestones.

Commissioner Anthony asked if there are memorandums or agreements in place between the organizations about the sharing of information, if reproductive services will be provided at the facilities, and what was achieved during the ramp-up phase.

Dr. See stated the relationships as partners were put in place during the planning process while waiting for project approval. The clinical care for all the partners will be tied to the county's electronic health record system. A separate evaluation and data collection system will be a secondary back-up to track outcomes, data, and other components. Reproductive health is part of the primary care core component.

Peter Elias stated the proposed project is trying to do something good, but at the same time there are many things that cannot be solved. He asked about the process of referral to higher levels of care.

Ms. Tullys stated the county has a youth mobile crisis team and clinicians in the area who would have the authority to transfer individuals to the crisis stabilization unit or other resources in the community. All youths will be provided service whether insured or uninsured.

Dr. Adelsheim stated he and other clinicians would ensure that, if a service was not available or there was not a capacity to address a need at the site, the young person would be linked to whatever service was required.

Commissioner Beall returned to the meeting and rejoined the Commissioners at the dais.

Commissioner Danovitch stated he has to leave but supports this Innovation project.

Public Comment

Adrienne Shilton spoke in support of the proposed project.

Roshelle Ogundele, Supported Employment and Education Specialist, Standard Center for Youth Mental Health and Wellbeing, spoke about the work of the youth advisory group.

Ana Lilia Soto, Youth Outreach Specialist, Stanford Center for Youth Mental Health and Wellbeing, stated the youth who are part of this project all expressed a desire to support the proposed project. She read the story of a young person involved in the project.

Derek Zhou, Student, Palo Alto High School, spoke in support of the proposed project. He shared his experience of being a youth in Santa Clara County and how the center would have helped him.

Maureen Bauman spoke in support of the proposed project.

Mandy Taylor spoke in support of the proposed project.

Rory O'Brien spoke in support of the proposed project.

Sandra Marley spoke in support of the proposed project.

Commissioner Discussion

Commissioner Beall stated the Senate Mental Health Caucus had a presentation from Dr. Adelsheim on what was going on in Australia and Vancouver and the concept being proposed in Santa Clara County. The members of the Caucus were highly enthusiastic about the idea. Several members plan to do legislation for this model in their communities throughout the state. Outcomes that demonstrate the impact for young people are the key.

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

The MHSOAC approves Santa Clara County's Innovation Project as follows.

Name: headspace

Amount: $14,960,943

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

ACTION

6: <u>San Diego County Innovation Plan</u>

Presenters:

- Alfredo Aguirre, LCSW, Behavioral Health Services Director, San Diego County
- Yael Koenig, LCSW, Behavioral Health Services Deputy Director, San Diego County
- Dean Sidelinger, M.D., MPH, Child Health Medical Officer, San Diego County

Commissioner Madrigal-Weiss recused herself from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Alfredo Aguirre, Behavioral Health Services Director, San Diego County, provided an overview, with a slide presentation, of the county demographics and community planning process.

Dean Sidelinger, M.D., MPH, Child Health Medical Officer, San Diego County, continued the slide presentation and discussed the need and what is currently being done in the county.

Yael Koenig, Behavioral Health Services Deputy Director, San Diego County, finished the slide presentation by discussing the problem, Innovative components, learning goals, and sustainability of the proposed Innovation project.

Commissioner Questions

Commissioner Anthony asked how the proposed project differs from the existing program.

Dr. Sidelinger stated the nurse home-visiting programs do screening using evidence-based tools for depression and anxiety. If a condition is identified, part of the advantage of home visiting with a nursing model is that they have a clinical background. They have training that can provide support to women with mild symptoms, but they are not mental health clinicians. Individuals with moderate to severe mental health conditions need to be referred to a mental health clinician through the primary care provider or the county behavioral health services, but it is often difficult to access the appropriate mental health clinician who can treat the client in the context of being pregnant or a new parent and focus on the bonding and relational aspects. This often lags from a week to a month or more to get into appropriate treatment. The proposed project would give additional training to the nurses to provide more adequate support, will continue beyond referral to a clinician, and will be a warm handoff later when the client needs additional help.

Vice Chair Aslami-Tamplen asked about parents with a child in a neonatal intensive care unit (NICU) or parents who have lost a child, because those are times that parents could use extra support.

Dr. Sidelinger stated one of the outcomes the proposed project is seeking is to reduce premature birth and thus reduce admissions to the NICU. Mothers and other caregivers are followed until the child is two years old. There is a strong network of peer support programs of families who have had similar experiences.

Peter Elias asked if there is an age range to participate in the proposed program.

Dr. Sidelinger stated the program focuses on teen parents to parents in their late thirties and forties.

Commissioner Alvarez stated home-visiting programs, particularly those funded by state dollars, are typically not flexible models. She asked how the county was able to contact with the Nurse-Family Partnership to allow for this experiment to their tried-and-true model. She also asked if telemedicine or telehealth services will be part of this project.

Dr. Sidelinger stated the proposed project will layer on top of the Nurse-Family Partnership model, not change it. The screening for depression and anxiety is built into that and referrals are made when families who are being served need higher levels of care. The proposed project will change when that referral will happen because the mental health clinician will be co-located. The Nurse-Family Partnership will provide additional training and support for the nurses to be better at providing support and linking families to additional services.

Mr. Aguirre stated the role of technology could be incorporated into the learning questions as part of the project.

Commissioner Alvarez asked if it would solve the problem of reaching this small portion of the population if home visits were reimbursed by Medicaid.

Dr. Sidelinger stated the number of individuals to be served by the proposed program is the number who currently receive additional mental health treatment. Funding home-visiting programs is currently a patchwork of multiple funding sources. Additional models for reimbursement for that service would be helpful.

Commissioner Beall stated the Senate heard AB 3032 today, which would require acute care hospitals to have maternal mental health programs including postpartum depression. Acute care hospitals are required to have a plan by 2020. Senator Leyva presented the bill and announced she would be the champion of this issue. Commissioner Beall stated she would be a powerful champion. He stated there will be a lot of interest in this program.

Peter Elias asked if the county will go into schools to let them know these services are offered.

Dr. Sidelinger stated the county has a strong relationship and gets referrals from pregnant/parenting teen programs. Incorporating school credit for the participants in this program has been a successful model in San Diego.

Peter Elias asked what services are offered to the fathers.

Dr. Sidelinger stated nurses try to engage and provide support to the father of the baby or other caregivers while they are in the home.

Public Comment

Sandra Marley stated all employment in the proposed project goes through an outside contractor. The speaker asked what work the county is doing. The speaker asked the Commission to stand up more for mental health patients.

Maureen Bauman spoke in support of the proposed project.

Rory O'Brien spoke in support of the proposed project. The speaker asked how the project will address postpartum disparities using culturally-specific methods, how the project plans to provide postpartum support to trans and gender-nonconforming parents who may have needs that are intersecting between their gender and the fact that they just gave birth.

Mr. Aguirre stated the county has evidence-based practices that are delivered with staff who represent the communities they serve. Hiring staff that reflect the community and applying those evidence-based models in the treatment and care coordination will prove to demonstrate cultural competency.

Chair Boyd asked staff to ensure that counties list out all populations that are marginalized, at-risk, or underrepresented in the formal presentations going forward.

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

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

Name: Accessible Depression and Anxiety Postpartum Treatment (ADAPT)

Amount: $4,773,040

Project Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Gordon, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

Commissioner Madrigal-Weiss rejoined the Commissioners at the dais.

ACTION

7: <u>San Luis Obispo County Innovation Plans</u>

Presenters:

- Frank Warren, MPP, MHSA Coordinator, San Luis Obispo County
- Nestor Veloz-Passalacqua, MPP, Innovation Coordinator, San Luis Obispo County

Nestor Veloz-Passalacqua, Innovation Coordinator, San Luis Obispo County, provided an overview, with a slide presentation, of the problem, Innovative components, learning goals, and sustainability of the two proposed San Luis Obispo County Innovation Projects.

Commissioner Questions

<u>3-by-3 Developmental Screening Innovation Project</u>

Commissioner Anthony asked how the county plans to coordinate these services with existing services such as First 5.

Mr. Veloz-Passalacqua stated the county's partner in the development of this project is First 5. They came together as part of the collaboration in the Innovation process to discuss gaps in services in the community and how to better engage the community to test feasible solutions.

Frank Warren, MHSA Coordinator, San Luis Obispo County, stated the proposed project will also feed into the county's portion of the larger Help Me Grow Initiative.

Commissioner Alvarez asked if the Innovation is that the questionnaire will be conducted in new settings.

Mr. Veloz-Passalacqua answered in the affirmative; it will be conducted in childcare, pediatrician office, and home settings.

Commissioner Alvarez asked about the process once the questionnaire identifies an at-risk individual.

Mr. Veloz-Passalacqua stated resources to make the referral will be part of the training. Once a screening instrument is completed, the pediatrician will have a conversation with the parents or primary caregiver. If a referral is needed, it will be processed. He stated an instrument has already been developed in the county to help develop that.

Commissioner Alvarez asked why the county is seeking Innovation funding and not PEI funding.

Mr. Warren stated this is a three-year test. Innovation provides the opportunity to learn what can then be made as a policy recommendation for PEI. The county is looking for best practices to be funded through PEI going forward.

Commissioner Alvarez suggested identifying lessons so the proposed project can be taken to scale to the childcare community at large or the early childhood community more broadly to ensure that health is integrated into early learning in order to be more successful.

SLO ACCEPTance Innovation Project

Commissioner Mitchell questioned why the training is for nine months.

Mr. Veloz-Passalacqua stated the county is partnering with a Cal Poly professor who has extensive knowledge of the LGBTQ community. His research has led the county to incorporate a nine-month process considering that there are many pieces that are applicable to the training program.

Commissioner Alvarez asked if the county had considered asking patients if there was a difference in the provider after the nine months of training.

Mr. Warren stated it is part of the evaluation design.

Public Comment

Mandy Taylor spoke in support of the proposed SLO ACCEPTance project.

Maureen Bauman spoke in support of the proposed projects.

Sandra Marley spoke in opposition to the proposed 3-by-3 Developmental Screening project. The speaker suggested the film "Three Identical Strangers" about triplets who did not find out they were triplets until they were 19 years old. The speaker asked who the personnel are, what the operating expenses are, and who $160,000 is going to for the proposed SLO ACCEPTance project.

Poshi Walker spoke in support of the proposed SLO ACCEPTance project.

Rory O'Brien spoke in support of the proposed SLO ACCEPTance project.

Commissioner Discussion

Action: Commissioner Madrigal-Weiss made a motion, seconded by Commissioner Anthony, that:

The MHSOAC approves San Luis Obispo County's Innovation Plan as follows:

Name: 3-by-3 Developmental Screening Partnership Parents & Pediatric Practices

Amount: $859,998

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

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

The MHSOAC approves San Luis Obispo County's Innovation Plan as follows:

Name: Affirming Cultural Competence Education & Provider Training: Offering Innovative Solutions to Increase LGBTQ Mental Health Care Access (SLO ACCEPTance)

Amount: $554,729

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

Chair Boyd restated three things agreed to earlier in the day because it will be important for staff to begin setting them up.

<u>Public Process for Agenda Setting</u>

Commissioners will call in and the public can listen in. This will be effective in September. Vice Chair Aslami-Tamplen will be supporting that effort.

<u>Public Process Engagement</u>

In the month of October, Chair Boyd, Vice Chair Aslami-Tamplen, and other Commissioners who wish to attend will be reaching out to public stakeholders to meet, engage, plan, and open a dialogue.

Communication

The Commission will work to better inform all Commissioners of Commissioner and staff activities.

GENERAL PUBLIC COMMENT

Stacie Hiramoto also represents the diverse organizations statewide that are included in REMHDCO's letter to the Commission. In the spirit of collaboration, the letter contains suggestions on organizing. The speaker thanked Chair Boyd for opening the door to making this Commission the best it can be. The speaker asked to reinstitute two General Public Comment sections on the agenda. There are members of the public who come from out of town.

Sandra Marley agreed with the previous speaker. The speaker asked how to find out about CBHPC meetings and if the public can attend, and asked when in October they will meet. The BBC put out a documentary on artificial intelligence and mind control three weeks ago. The speaker recommended watching that program. On Sundays at 9:00 in Sacramento on C-SPAN is a show titled "Prime Minister's Questions" to help individuals familiarize themselves with parliament. The speaker cautioned not to let the Legislature take over the Commission.

Peter Elias thanked the Commission for including him in the meeting. It was a good experience.

ADJOURN

There being no further business, the meeting was adjourned at 4:21 p.m.

Back to Agenda

AGENDA ITEM 2

Action

September 27, 2018 Commission Meeting

Kings County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of Kings County's request to fund the following Innovative project:

(A) **Multiple Organization Shared Telepsychiatry (MOST) Project - $1,663,631**

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.

- Kings County proposes to offer Telepsychiatry services**,** with the inclusion of peer and parent peer navigators, for the residents living in their rural community with the hopes it will reduce individuals from needing crisis services in the emergency room or involvement with the criminal justice system. The County claims therapy via Telepsychiatry is medically based and the inclusion of peers is new and will hopefully change the model to one that is of wellness and recovery.

Presenters for Kings County's Innovation Project:

- Ahmad Bahrami, MBA., Program Manager (MHSA Coordinator/Ethnic Services Manager), Kings County
- Unchong Parry, MPA, Deputy Director, Kings County
- Katie Arnst, MA, Deputy Director, Kings County

Back to Agenda

Enclosures (3): (1) Biographies for Kings County's Innovation Presenters; (2) Multiple Organization Shared Telepsychiatry Staff Analysis; (3) Multiple Organization Shared Telepsychiatry Project Brief.

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

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

http://mhsoac.ca.gov/document/2018-09/kings-county-innovation-plan-multiple-organization-shared-telepsychiatry-most

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

Name:	Multiple Organization Shared Telepsychiatry (MOST) Project
Amount:	$1,663,631
Project Length:	Three (3) Years

KINGS COUNTY behavioral health kcbh.org

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

Innovation Plan Presentation for the Multiple Organization Share Telepsychiatry (MOST) Program

List of Presenters

Ahmad Bahrami, MBA. Program Manger (MHSA Coordinator/Ethnic Services Manager)
Unchong Parry, MPA Deputy Director
Katie Arnst, MA Deputy Director

Presenter Bios in relation to the Innovation Project

Ahmad Bahrami, MBA has been a program manager with Kings County since 2009. He is currently the MHSA Coordinator and Ethnic Services Manager for the County. Mr. Bahrami has been involved with each of the County's past Innovation Plans. He has been the lead on the current proposed Innovation Plan.

Unchong Parry, MPA is the Deputy Director overseeing the administrative divisions of the department. Previously she was the department's fiscal manager. She has overseen the department's budgets and the budget for this project. Ms. Parry's team will assist with the implementation of the program from the administrative side.

Katie Arnst, MA is the Deputy Director overseeing the clinical services divisions for the department. This project once approved shall reside with her direct services teams and services providers. Ms. Arnst shall coordinate the implementation of the MOST program for the county and provide oversight of the daily operations.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— KINGS COUNTY

Innovation (INN) Project Name:	**Multiple Organization Shared Telepsychiatry (MOST) Project**
Total INN Funding Requested:	**$1,663,631**
Duration of Innovative Project:	**Three (3) Years**

Review History:

Approved by the County Board of Supervisors:	June 26, 2018
County submitted INN Project:	September 5, 2018
MHSOAC consideration of INN Project:	September 27, 2018

Project Introduction:

Kings County proposes to offer Telepsychiatry services**,** with the inclusion of peer and parent peer navigators, for the residents living in their rural community with the hopes it will reduce individuals from needing crisis services in the emergency room or involvement with the criminal justice system. Due to the limited amount of psychiatrists providing service in the County (only two who serve Medi-Cal eligible individuals), Kings County would like to provide Telepsychiatry services by having the psychiatrist located at a distant location and the consumer would be provided a designated private room for the psychiatric appointment and would be greeted and welcomed by peer staff on-site who may also be able to provide support to those seeking treatment, if needed. An attached, secured room would also be staffed by a psychiatric technician who would be responsible for issuing medications as prescribed by the psychiatrist. The County claims therapy via Telepsychiatry is medically based and the inclusion of peers is new and will hopefully change the model to one that is of wellness and recovery.

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that 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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The County states this innovation project meets the primary purpose of increasing the quality of mental health services by incorporating peers into a Telepsychiatry model

based on wellness and recovery and will meet the innovation criteria by making a change to an existing practice not yet demonstrated to be effective, including but not limited to, adaptation for a new setting, population or community.

The Need

Kings County states they are a rural county with a population of approximately 150,000. The County indicates they have a high poverty rate along with a high rate of serious mental illness. Statistics by the County reflects that about 19% of Kings County residents live in poverty and 38% are Medi-Cal eligible. In addition, the County states they have the second highest rate in California for adults with a serious mental illness, 6.9%, while the rate for children with severe emotional disturbance in their County is 8.0%. Compounding this issue, the County claims, is the lack of available psychiatrists in the County who provide services for consumers with Medi-Cal. Currently, Kings County has only two (2) psychiatrists providing services for consumers with Medi-Cal insurance resulting in an average wait time of nearly 26 days to be seen for an initial appointment. The County states the shortage of psychiatrists who provide services to Medi-Cal eligible consumers has led to consumers with mental illnesses to be improperly served in emergency room settings or with encounters within the criminal justice system.

Research supports the County's assertion that there is a large number of those living in poverty. Of the total population of adults living in Kings County who are 18 years of age and older (n=84,616), approximately 83% (n=70,717) live above the federal poverty level. Only 16% (n=14,099) of adults live below the federal poverty level. The Federal Poverty Level is an economic measurement used to determine if an individual or family income level permits them to be eligible to receive assistance through federal programs and benefits.

The Response

In an effort to lessen wait times for consumers in Kings County to see a psychiatrist for their mental health needs, the County is proposing to set up Telepsychiatry suites staffed by peers, parent peers, psychiatrist technicians, and an office assistant.

The County would like to establish Telepsychiatry suites, shared by multiple service providers, with the hopes that consumers will receive a higher quality of care combined with improved time waiting to be seen by a psychiatrist. Psychiatrists will provide services to Kings County residents from outside the County. All psychiatrists who will provide Telepsychiatry will be Board Certified and shall be able to bill Medi-Cal for services provided. Eventually, Kings County will form and manage Telepsychiatry suites in three (3) cities within the County: Hanford, Avenal, and Corcoran. The County states that all planned locations within the County are already owned and operated by Kings County.

1. Hanford Telepsychiatry Suite
    - This initial Telepsychiatry suite will be approximately 1500 square feet and is comprised of several rooms within the suite.

- Consumers visiting this location will be assisted by staff consisting of a bilingual office assistant/receptionist, peer navigator, parent peer navigator, psychiatric nurse or psychiatric technician.
- Office Assistant will assist with the scheduling of appointments, appointment reminders and following up with consumers if needed.
- Peer Navigators and Parent Peer Navigators will each have their own office inside the suite to meet with consumers before and/or after appointments.
- Psychiatric nurse or psychiatric technician will have their own confidential space.
- There will be a confidential medical room where health screenings and administration of medications will occur. This room will be securely locked and only designated medical staff will have access to this room. Select medications that require injection will be stored in this restricted room and refrigerators will be available so that medications can be properly stored [in accordance with CCR, Title 9, Section 1810.435(3)].
- Medications will be prescribed by the psychiatrist and filled at the consumer's pharmacy of choice. Medications requiring injection will be given by either the psychiatric nurse or psychiatric technician in the medical room.
- A large room with soothing light will be available for consumers who are in need of a quiet or calming space.
- Actual rooms for Telepsychiatry are large enough for the peer support to attend the telemeeting at the request of the consumer, if desired.
- Providers in the same building as the Telepsychiatry Suite will include the following:
  - Quest Diagnostics - may provide lab work upon request of the psychiatrist
  - AspiraNet – offers wraparound services for children and youth and will be located in the same building complex
  - Mental Health Systems, Inc. – offers daily engagement utilizing a team approach with integrated resources and services
- Other community resources nearby include a health clinic which is about a half-mile from the Hanford location and will receive consumers who may be in mental health crisis to the Telepsychiatry suite for help.

2. Avenal Telepsychiatry Suite
   - This location will share the staffing structure with the Hanford site (including the peer and peer navigators)
   - The County anticipates this site will be providing services in January 2020.
   - This suite location will be housed in the same building as the Kings County Behavioral Health Services, Human Services, and Public Health to allow consumers a smoother continuum of care and resources.
   - This location is county owned and operated – staffing will be covered by budgeted innovation funds.
   - Similar to the Hanford listed above, there will be a secure medication room for the proper storage of medications.
   - Medication prescription procedures will be similar to the Hanford suite

3. Corcoran Telepsychiatry Suite
    - This location will share the staffing structure with both the Hanford and Avenal sites (including the peer and peer navigators).
    - The County anticipates this suite will begin providing services in January 2021.
    - This location is already county owned and operated – staffing will be covered by budgeted innovation funds – and will be located in the County's Public Health building in Corcoran.
    - Dependent upon what is learned from the Hanford and Avenal suites, the County states this suite may need to incorporate modifications and will further vet out the specific services and provider resources that will be offered within the same building.

As part of the research into this innovation project, Kings County reached out to neighboring counties which included Tulare, Mono, Alpine, Colusa, and Madera Counties to inquire into the dynamics of their particular telepsychiatric services offered in their respective counties. Kings County found that none of their neighboring counties had incorporated the use of peers and parent peers as part of their telepsychiatric treatment team. The County hopes to learn if the use of peers and parent peers will improve outcomes for consumers.

The County states peers will be initially hired as part-time contracted employees and then will become full-time County employees with benefits. Peers will be certified to meet criteria established in Senate Bill 906 and will be trained in areas including but not limited to: confidentiality, pharmacology, cultural humility, and case management services. In addition to providing advocacy for the consumer, peers may also sit and attend therapeutic sessions, if asked. Kings County will consider all peers, including those who may have prior criminal justice involvement in the recruitment efforts. Ultimately, the County asserts peers with lived experience will be hired.

Kings County also reached out to the nearby Naval Air Station in Lemoore to inquire into their telepsychiatric services. The County was informed that psychiatric services was available at the hospital on base but only for active duty personnel. Again, the County found that services provided at Lemoore Naval Air Station do not utilize peers as a service component.

The Community Planning Process

Kings County states this innovation project was developed as a result of the identified need during their three (3) year community planning process. Kings County held their 30-day public comment period beginning December 20, 2017 and received Board of Supervisor approval on January 23, 2018. The MHSOAC shared this Innovation Project with stakeholders beginning August 2, 2018. It is not known whether comments were received at the County level; however, no letters of opposition or support were received at MHSOAC in response.

After receiving approval from their Board of Supervisors for this innovation project, Kings County continued developing this innovation project with the community to ensure

their (community) voices were heard and involved in every step of this project. Stakeholder focus groups were held in June 2018 with families and consumers. An additional public hearing was held on June 25, 2018 and this updated and final innovation project was re-presented to their Board of Supervisors on June 26, 2018, obtaining final approval.

The County states the innovation project was approved by the MHSA steering committee, comprised of 23 members, and involved interviews with pivotal members of the Kings County community including, but not limited to: stakeholders, consumer and family members, Tribal Communities, various community providers and community based organizations, school district assistant superintendents, veterans, and governmental agencies. Additionally, the County held various focus groups in the community which were also linguistically appropriate given the County's predominantly large Latino/a populations.

As part of MHSA General Standards for cultural competency, Kings County states that the staff employed in the Telepsychiatry suites will be bilingual as well as culturally competent as Kings County is a largely Spanish speaking population and home to Native American Tribal Communities as well as a large veteran population.

Learning Objectives and Evaluation

Kings County plans on implementing a program that will enable the shared use of telepsychiatric suites at multiple sites within the county. The program will allow for both mental health service providers and county departments to provide these services to consumers within the county. Specifically, the County will target Medi-Cal eligible consumers who are in need of psychiatric treatment services, with a goal of providing services to 256 individuals. Kings County seeks to determine if the MOST program will help to transform the "traditional medical model" of their current system of care into a "wellness and recovery" oriented system of care by incorporating peer and family staff into these telepsychiatric services.

To guide their project, Kings County has identified two main learning *goals*, as well as several intended *outcomes*:

Goal 1: Can a telepsychiatry program that included a peer and family component as part of the treatment team help transform psychiatric services that are based on a medical model to a wellness and recovery-based system of care?

- Outcome 1: Improved perceived value of peer involvement in psychiatric care among consumers, providers, and psychiatrists.
- Outcome 2: Consumers will self-report they believe they are meeting their own wellness and recovery goals.

In order to gather the data necessary to measure these outcomes, the County will develop and use surveys to be administered to both consumers and service providers. The County will measure changes in perceptions between intake and over the duration of the project as well as self-report measures among consumers on meeting their wellness and recovery goals.

Goal 2: Can sharing of telepsychiatric services with other local services providers (including community based providers) improve coordination of care and outcomes of program participants?

- Outcome 1: Consumers will be able to transition to a lower level of care as a result of better coordination.
- Outcome 2 A reduction in wait times to see psychiatrists for initial and follow-up appointments
- Outcome 3: A reduction in the number of mental illness crisis hospitalizations for MOST participants.
- Outcome 4: A reduction in the number of individuals seen by hospital emergency departments for mental illness over the duration of the project
- Outcome 5: A reduction in the number of individuals with mental illness returning to jail as a result of participation in the MOST program.

The majority of data necessary to meet the outcomes of Goal 2 will be obtained from the County's shared electronic health records (EHR). The County will track changes in levels of care, time between referral to initial appointment using the shared EHR, as well as the number of emergency department visits and crisis hospitalizations among MOST participants. For comparisons, Kings County states that comparison groups will be established from individuals in a similar program, or by establishing a baseline of individuals who have historically utilized similar services.

Kings County will enter into a contract with an external evaluator who will analyze the data gathered and complete the final evaluation report. Throughout the duration and at the conclusion of the project, the County will share findings from the project in a number of different ways, including: presentations to the Kings County Board of Supervisors, the Behavioral Health Advisory Board, various support, local outreach, and education programs, at local and state conferences, among others.

The Budget

The total proposed expenditures for this three (3) year project is $2,138,631 which includes Medi-Cal reimbursement and the use of Community Support and Services funds. The total innovation budget is $2,054,000 and the County is seeking approval for the use of MHSA innovation funds in the amount of $1,663,631. The County states the use of MHSA funds will be for direct services provided for consumers and the remaining components of the budget will be leveraged by other resources. The County anticipates Medi-Cal reimbursement in the amount of $325,000 and the use of MHSA Community Service and Support funds in the amount of $150,000.

The majority of the budget is going towards personnel costs which accounts for $1,883,800 (88%) of the proposed expenditure total. There are a total of seven (7) staff required for this project which includes:

- Two (2) Psychiatrists
- Two (2) Peer / Parent Peer Support Specialists

- Two (2) Psychiatric Technicians
- One (1) Office Assistant

Kings County will make one-time purchases in the amount of $25,000 (1.2%). These costs will cover the purchase of telepsychiatry equipment, furniture for the suites, computer equipment and technology support/licensing costs for the additional staff.

The County's direct costs total $145,600 (6.8%) of the total innovation budget. This will cover the consultant costs in the amount of $10,000 and a total of $120,000 for the evaluation, which will be completed by a third party evaluator. Lastly, $15,600 will cover the cost for County staff to provide technology support for the suites along with cost to secure internet connections needed to provide telepsychiatry services.

In reference to Assembly Bill 114, the County intends to use funds subject to reversion referenced in their Annual Revenue and Expenditure Reports. Funds subject to reversion including interest will be utilized from the following fiscal years to fund this project:

- FY 10/11 - $127,786
- FY 12/13 - $182,585
- FY 13/14 - $254,599
- FY 14/15 - $361,361
- FY 15/16 - $300,063
- FY 16/17 - $377,404
- Interest - $59,833
- **TOTAL: $1,663,631**

Regarding sustainability, the County will seek Medi-Cal reimbursement in the amount of $325,000 annually and will also utilize funding from MHSA Community Support and Services. If needed, the County also states they will utilize savings from other programs in the County to ensure this project will be sustainable.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://www.investopedia.com/terms/f/fpl.asp

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

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-09/kings-county-innovation-plan-multiple-organization-shared-telepsychiatry-most

MULTIPLE ORGANIZATION SHARED TELEPSYCHIATRY

EXECUTIVE SUMMARY

Kings County seeks to *"make a change to an existing practice that has not yet been demonstrated to be effective, including but not limited to adaption for a new setting, population or community*". Kings County is proposing the Multiple Organization Shared Telepsychiatry (MOST) project as its innovation plan that will be a catalyst to change an existing practice. The MOST project is seeking to expand much needed psychiatric services by establishing multiple shared telepsychiatry suites that will be accessed by multiple providers. Additionally, the MOST program seeks to uses these shared services to improve care coordination and to infuse the lived experience of peers into the provision of psychiatric services.

WHY

Our research for this project found that there is not an existing model in California where a County operated psychiatric or telepsychiatric services (an often limited and costly resources) is shared with its service providers, nor did our research yield examples of where peers were paid members of any telepsychiatric provider team. Kings County experiences a significant shortage of psychiatric services based on being a small and rural county. Often these services, when available have been based on a more traditional medical model of care, versus one that is based on a wellness and recovery model of care.

- Telepsychiatry allows for increased psychiatric care hours in rural communities such as Kings County, which currently has only one contracted psychiatric care location/provider for people with Severe Mental Illness (SMI).
- However, telepsychiatric hours themselves do not overcome the disconnect between the lived experience of overcoming symptoms of mental illness and the decision to work with a psychiatrist to begin to participate in medication treatment (taking and adjusting medications).
- Stakeholders have taught us that peers and family members are the missing link on the psychiatric road to recovery.

HOW

The MOST project will go far beyond addressing a serious psychiatric shortage in a small and rural community, it will not just build capacity, improve access to care, but its focus will be to move telepsychiatry from a medical model of care to one that is based on wellness and recovery and thus improving the overall coordination of care and the consumers' experience. The outcome of this project will increase access to timely care, creating paid peer roles in the system of care, and increase the number of individuals receiving care in the community instead of jails, hospitals and emergency departments.

- Create a centrally located, county run, telepsychiatry suites that will provide psychiatric care for consumers on our highest risk and highest need teams.
- Provide a peer based service model of psychiatric care where peers and family members play a key role in each psychiatric appointment.
- Double the number of psychiatric hours available to our SMI consumers while providing paid Peers Support Specialists and Parent Peer Support Specialists partners to collaborate with each consumer prior to their psychiatrist appointment.
- Use county Electronic Health Record (EHR) to connect telepsychiatric suites/services to all county treatment team providers and to alert Peers Support Specialists and Parent Peer Support Specialists to any specific needs or concerns for each consumer.
- Ensuring treatment teams are focused on individualized care from a cultural humility approach to care.

WHO

The stakeholders of Kings County identified a need for additional psychiatric services that would allow for greater access, timely access, and to allow consumers to be served in the community instead of jails, hospitals and emergency departments. Having teams that could specialize on populations such as children would be critical in improving engagement, care and outcomes. The County shall staff and operate these telepsychiatry suites in various county locations, but share the resources with our children's service providers and adult services providers. Designating specific days for each population and provider shall be established, ensuring appropriate staff are scheduled for those populations (i.e. child psychiatrist for the children).

- Provide timely adult and child telepsychiatric care with a peer supported voice to help consumers and their family members engage effectively in psychiatric treatment.
- Paid Peer Support Specialist and Parent Peer Support Specialist will provide the key personal link between the consumers, care providers and psychiatrist.
- Paid Peer Support Specialist and Parent Peer Support Specialist will use their lived experience to model their own wellness and communicate the path to recovery by supporting the consumer's journey with medication treatment.

GOALS

The focus for the program from its on-set has included the ability to be sustainable. The MOST project has been designed in a manner which will allow it to transition to a fully sustainable service at the conclusion of the Innovation plan term, and allow for other public funding, specifically Medi-Cal reimbursement and Mental Health Services Act (MHSA) funding to carry the program forward. The ability to provide access to psychiatric care in a more timely and coordinated manner shall reduce the number of consumers who are hospitalized, incarcerated, or admitted into the emergency room, and that shall yield significant cost savings that will also support the program's continuing sustainability.

- Create and sustain community level of psychiatric care.

- Establish a system care for telepsychiatry that is based on wellness and recovery model.
- Provide for our highest need/risk consumers with personal and timely care coordination between psychiatrist and peer supported treatment teams.
- Create a climate of first choice care so that consumers do not feel the need to seek out treatment in the Emergency Department or avoid treatment due to negative experiences.
- Having timely access to community level psychiatric care is needed to support early intervention and early psychosis future programs.

COST

Kings County has **$1,663,631** dollars available for Innovation funding for the MOST project. Total cost of the MOST project is slated at $2,138,613. Kings County is requesting approval for $1,663,631 from the Mental Health Services Oversight and Accountability Commission for its proposed innovation plan. Kings County has estimated revenues of Medi-Cal FFP at $325,000 or more during this project to close the funding gap. Additionally, $150,000 of MHSA funding will be used to fund the program in the final year. The MHSA funding will focus on the Peer Support Specialist and Parent Peer Support Specialist salaries, to ensure that peer components of the program shall continue in the system. The program shall also seek to maximize revenues from certified peers that will become available through the SB 906. The County's MOST project has contingencies on ways the program can and shall be sustained upon completion of the Innovation Plan's three-year term.

- Total cost of the program is $2,138,613.
- $1,663,631 of Innovation funding is being requested for the MOST project.
- The program has already identified revenues to close the program funding difference, but has also identified financial plans to ensure the program shall be sustainable upon completion of this plan.
- Kings County is investing $120,000 (up to $40,000 a year) into the evaluation of the project. The evaluation component is vital for this program into order to identify if this program improved care coordination and moved this system of care from a medical model to one that is based on wellness and recovery.

CONCLUSION

The Kings County Innovation Plan- MOST Project seeks to be transformative and innovative while simultaneously addressing each of the five MHSA Values. The MOST Project promotes *Wellness and Recovery*, is rooted in *Cultural Competency/Humility*. The MOST project is *Client and Family Driven*; it will *Integrate the Services Experience* by increasing collaboration of service providers, modalities of care, and care coordination. The MOST project has been driven by *Community Collaboration* and will require continued community collaboration for its longevity. Kings County's approach to innovation can be summarized by the words of Robert Kennedy, "*Some people see things as they are and ask why? We see things that are not yet and ask why not".*

Back to Agenda

AGENDA ITEM 3

Action

September 27, 2018 Commission Meeting

Los Angeles County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Los Angeles County's request to fund the following two (2) new Innovative projects for a total amount of $34,624,902 (see below for project breakdown). The duration of each of these projects is five (5) years for the Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community and three (3) years for the Therapeutic Transportation.

(A) **Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community - $16,282,502**

(B **Therapeutic Transportation - $18,342,400**

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.

- Los Angeles County proposes to develop a collaboration between the Public Guardian's (PG) office and the Department of Mental Health and peers. This pilot project is intended to create a team based, recovery focused approach for conservatees in the community (in and out of board and care facilities). It is anticipated that this team, made up of a clinical advocate and a peer mentor will increase conservatees' access to services, increase their quality of life and community integration.
- Los Angeles County Los Angeles County proposes to utilize equipped vans staffed with mental health professionals to provide transportation to consumers on involuntary holds to the psychiatric hospital. Staff transporting consumers will consist of a clinician, a medical case worker and a peer support specialist. The County states that outfitted vans may also help to reduce the stigma

associated with hospital transport as consumers are typically transported via ambulance or accompanied by law enforcement.

Presenters for Conservatees Living in the Community Project:

- Debbie Innes-Gomberg; Deputy Director, Los Angeles County
- Maurnie Edwards, Health Program Analyst, Los Angeles County
- Connie Draxler, Los Angeles Public Guardian
- Evelio Franco, Team Supervisor, Los Angeles County

Presenters for Therapeutic Transport Project:

- Debbie Innes-Gomberg; Deputy Director, Los Angeles County
- Anthony Ruffin, Outreach Worker, Los Angeles County
- Paul Stansbury, Family Member

Enclosures (5): (1) Biographies for Los Angeles County's Innovation Presenters; (2) Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community Staff Analysis; (3) Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community Project Brief; (4) Therapeutic Transportation Staff Analysis (5) Therapeutic Transportation Project Brief

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

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

http://mhsoac.ca.gov/document/2018-09/los-angeles-county-innovation-project-ongoing-focused-support-improve-recovery

http://mhsoac.ca.gov/document/2018-09/los-angeles-county-innovation-projecttherapeutic-transportation-tt-september-27

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

Name:	Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community
Amount:	$16,282,502
Project Length:	Five (5) Years
Name:	Therapeutic Transportation
Amount:	$18,342,400
Project Length:	Three (3) Years

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Biographies for Los Angeles County Presenters

Conservatees Living in the Community

Debbie Innes-Gomberg, Ph.D.
Dr. Innes-Gomberg received her PhD from CSPP-LA in 1992 and is the Deputy Director over Program Development and Outcomes for the Los Angeles County Department of Mental Health. Over her 25 year career she has assumed leadership roles in Jail Mental Health Services, Adult System of Care, served as a District Chief for the Long Beach/South Bay areas of Los Angeles County and oversees the administration of the Mental Health Services Act. Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the MHSA and on outcome and evaluation of mental health programs.

Maurnie Edwards
Maurnie V. Edwards currently works with the Los Angeles County Department of Mental Health, Program Development and Outcomes Division as a Health Program Analyst II. Since 1998, she has worked in various administrative capacities which included the Public Guardian's office for seven years. She began as a staff assistant and quickly promoted to Deputy Public Conservator I, Deputy Public Conservator II and Senior Public Conservator. She developed a specialty of high risk, high utilizer caseload management, managing over a 100 consumer caseload. Ms. Edward's passion to serve consumers challenged by mental health and her understanding of the recovery journey continues to inspire other mental health endeavors. She has developed training programs for staff and community based organizations throughout Los Angeles County, one of the most noteworthy are the coordination of the Mental Health Community College Conferences which addressed anti-stigma and anti-discrimination mental health awareness and incorporated consumers, family members and parent partners/parent advocates in the very successful outreach campaign. Rooted in her Public Guardian Office experience and service, she continued to promote the importance of mental health awareness through her coordination of Countywide Mental Health First Aid (MHFA) Trainings and became a certified Mental Health First Aid Instructor. She has established herself as a "master" MHFA instructor mentoring and supporting those recently certified in the Department as well as DMH Community Partners personnel and continues to be called upon as a lead instructor by the Department, community organizations and other external entities.

Connie D. Draxler
Connie Draxler is the Deputy Director of the Los Angeles County Office of the Public Guardian, the largest and oldest Public Guardian office in the State of California. She is responsible for the day to day operations of the LPS and Probate conservatorship programs. Ms. Draxler has served in this capacity since 2009. Prior to her move to Los Angeles County, Ms. Draxler worked in the Orange County Public Administrator/Public Guardian office for 14 years, starting as a line deputy in the LPS program and finishing as the Chief Deputy responsible for day to day operations. Ms. Draxler received her Bachelor of Science degree in Rehabilitation Psychology from the University of Wisconsin-Madison and her Master of Public Administration from California State University-Long Beach. Ms. Draxler has served on the Executive Board of the California State Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC) holding all board positions including Program Chair of the annual conference and President. Ms. Draxler currently co-chairs the Legislative Committee for the PAPGPC Association.

Evelio Franco
Evelio is a Licensed Marriage and Family Therapist and has been working for eight years as a case manager, clinician and most currently a Clinical Supervisor for the Los Angeles County Department of Mental Health Service Area 3 FSP program.

Therapeutic Transportation Project

Debbie Innes-Gomberg, Ph.D.
Dr. Innes-Gomberg received her PhD from CSPP-LA in 1992 and is the Deputy Director over Program Development and Outcomes for the Los Angeles County Department of Mental Health. Over her 25 year career she has assumed leadership roles in Jail Mental Health Services, Adult System of Care, served as a District Chief for the Long Beach/South Bay areas of Los Angeles County and oversees the administration of the Mental Health Services Act. Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the MHSA and on outcome and evaluation of mental health programs.

Anthony Ruffin
I have been working in the field of social services for over past 19 years. During this time, I have participated in the piloting and implementation of new programs in Los Angeles targeting the most vulnerable and at-risk homeless persons living on the streets or in hospitals in Los Angeles. Specific programs include the pilot FUSE programs, SIF, and Hollywood Top 14 and Skid row projects. Prior to working with The Department of Mental Health, I served as an Outreach Specialist throughout the County of Los Angeles with homeless service providers serving SPAs 2, 4, 5 and 6. I have extensive experience working with some of the most challenging underserved populations in Los Angeles including those experiencing chronic homelessness.

Bentley “Paul” Stansbury, Jr.

Paul Stansbury is a retired college administrator currently serving as a volunteer in the positions of, the President of the Los Angeles County Coordinating Council of NAMI affiliates, President of National Alliance on Mental Illness (NAMI) South Bay affiliate in Los Angeles County, President of the Homes for Life Foundation, Board Member of Starview Children and Family Services Board, and Co-Chair of Service Area 8 of Los Angeles County Advisory Committee. He did serve for a couple of terms on the State of California Mental Health Services Oversight and Accountability Commission’s Committee on Funding and Policy. He graduated from the US Air Force Academy with a BS in Engineering Management, received a Master’s in Business from USC, a Masters in Sociology from California State University Long Beach and a doctorate in higher education management from Pepperdine University. He became involved in the National Alliance on Mental Illness when one of his sons developed a mental illness and is very indebted to the support and education that NAMI and NAMI families have provided to his family and of the services provided by the mental health system.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— LOS ANGELES

Innovation (INN) Project Name:	**Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community**
Total INN Funding Requested:	**$16,282,502**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	TBD[1]
County submitted INN Project:	July 16, 2018
MHSOAC consideration of INN Project:	September 27, 2018

Project Introduction:

Los Angeles County proposes to develop a collaboration between the Public Guardian's (PG) office and the Department of Mental Health and peers. This pilot project is intended to create a team based, recovery focused approach for conservatees in the community (in and out of board and care facilities). It is anticipated that this team, made up of a clinical advocate and a peer mentor will increase conservatees' access to services, increase their quality of life and community integration. (p. 2). Secondarily it is anticipated that this project will create better communication between the Guardian's Office and the Department; resulting in fewer conservatees failing to be adequately served and will promote a culture of recovery, introducing a new application to the mental health system (page 1).

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?

[1] This plan was included as part of the County's AB 114 Reversion Plan. The AB 114 Reversion Plan was posted on March 23, 2018 and approved by the Board of Supervisors on June 6, 2018.

- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project 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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

The County reports that many individual conserved by the Public Guardian's office frequently do not have any other contact outside of that representative. Further, those contacts individuals may have with the PG's office many not necessarily be recovery oriented either because of caseload size or philosophical doubts as to recovery process itself. Additionally, the County reports that "peer support has not been a key component of treatment" (page 1) and expanding the role of the peer mentor to the conserved client population is an important reflection of the recovery message.

In 2017, The "L.A. County Board of Supervisors Tuesday voted to pursue an overhaul of the Office of the Public Guardian by looking for ways to bring down caseloads, improve the quality of services, and ensure those who qualify for public guardianship are getting adequate care: https://www.scpr.org/news/2017/08/08/74469/conservatorship/ At that time it was reported that case load size in the PG office was approximately 1:70-110 (staff member to consumer) and at the time of the Board's decision to overhaul the PG's office, it was estimated that the office served approximately 2700 individuals.

Large caseloads are not a new issue to this office and are not the only problem or concern addressed by this innovation. For example, "The LAPG has computerized records dating back from 1984, allowing an important before and after picture of incapacitated persons over time. In a report dated 2005, it is reported that "based on a guardian-to-ward ratio of 1:30, staff-to-client ratios were too high in 1979 (average load of 105 persons per caseworker) and have not declined significantly (84 per deputy public guardian) in over 20 years." https://www.americanbar.org/content/dam/aba/administrative/law_aging/PublicGuardianshipAfter25YearsIntheBestInterestofIncapacitatedPeople.authcheckdam.pdf

The County reports that Board and Care homes which used to provide some "community" services to persons staying there are closing operations since the reimbursement rate from the state have traditionally been low and home owners are incentivized to do other things with their properties due to the rising value of homes and land.

If available, the County may wish to describe current need, or the problem it is trying to address with this Innovation, related to recidivism and re-hospitalization for the conserved population.

The Response

The County believes that an "enhanced array" (email dated August 21, 2018) of services will serve as platform for bringing about a collaboration between the PG's office, individuals conserved by the PG's office and the county behavioral health department.

The County proposes to develop 16 teams for each of its two services areas. Each team will include a clinician and a peer mentor who will join with the PG office to provide field based, community services; essentially to meet the conservatee when they have the most natural supports. These teams will interface with the Public Guardian's office to provide support, case management, medication support, rehabilitation services, group therapy and psycho-educational groups and consultative services. Each team will serve 50 conservatees. Services provide by these teams will be field based and are intended to increase autonomy, improve the quality of life for the conserved person and help with community integration.

Additionally, the teams will provide in-service training for clinical advocates and peer mentors through a series of team meetings in both the community and in the board and cares for those conservatees who live there. All of the services for board and care conservatees will be conducted with the expectation that a conservatee can recover in the same way that other conservatees in the behavioral health community are believed to recover.

A critical piece to this collaboration will be having peers on the teams, providing trainings to the PG's office, and community resources which may be utilized by the conservatee, as well as provide role models as the conservatees begin to participate in decision making about their treatment options and what the road to recovery would look like.

The Community Planning Process

The County indicates that the planning process for this innovation began in December 2017 with the development of an innovation pipeline group. This group provided an INN feedback form and INN guidelines. The pipeline group had met 8 (eight) times in 2018 (as of date of the writing of this proposal) and 30 proposals were submitted. Seven (7) proposals did not meet the requirements for Innovation, 2 (two) proposals were forwarded to veterans groups, 6 (six) proposals were referred for PEI services. Some proposals were combined with others. Ultimately there were three (3) proposals that addressed the issues of conservatees.

These were presented to the System Leadership Team in January and April 2018 and feedback from these meetings was incorporated into the development of this plan. This project was also shared with the Client Advisory Board, The Peer Resources Center, The disability underserved Cultural Community Group, Services Area Advisory Chairs, National Alliance on Mental Illness (NAMI) chairs, and Program Manager III's throughout the County. The Underserved Cultural Communities and the Cultural Competency Committees had this plan presented to them on May 14 and June 13, 2018, respectively.

The Los Angeles County stakeholder process meets the requirements of Welfare and Institutions Code section 5848 and California Code of Regulations section 3300, in terms of group diversity and process training.

This Innovation project was shared with MHSOAC stakeholders August 13, 2018. No comments or letters of support or opposition have been received to date.

Learning Objectives and Evaluation

Los Angeles County plans on implementing a community-driven approach to increase access to mental health services for conservatees living in the county. The project will target adults on conservatorships, from diverse cultural backgrounds living in Los Angeles County conserved through the Public Guardian's Office (PG). Throughout the duration of the project, the County hopes to serve approximately 800 individuals.

To guide their project, Los Angeles County has identified six main learning questions:

1. Does a recovery based advocacy approach help improve client quality of life?
2. Are rates of recidivism and incarceration reduced as a result of these services?
3. Did this project assist conservatees with increasing their sense of hope and control over symptoms?
4. Did utilization of outpatient mental health services increase?
5. Was the average length of conservatorship reduced?
6. Was a secondary gain of basic health outcomes realized, due to the support and advocacy of the community support team?

In order to gather the data necessary to measure these outcomes, the County will develop instruments to measure client quality of life, track length of hospitalizations, rates of inpatient recidivism and incarceration, rates of conservatees accessing services, and length of conservatee enrollment in the project. Additionally, the County will use a questionnaire such as the Recovery Assessment Scale Domains Stages (RAS-DS) to examine client sense of hope and control over symptoms, and develop health measures to examine positive changes in conservatee health after initiation into the project (**See pg. 5 of County plan**). All data collected will be compared to conservatees that are not enrolled in the program. **The County may wish to describe how baseline data will be established in order to determine whether or not outcomes have been met.**

In addition to examining the learning questions above, the County, through the project, intends on promoting interagency collaboration between the clinical advocate/peer mentor teams, the PG, family members, and other community agencies and the conservatee. Outcomes from the project will inform shared learning and the need for further support and training for the PG and community conservatee support team members. An in-house psychologist and analyst will support data collection and analysis, as well as the completion of the final evaluation report. Results and lessons learned from the project will be shared across local and state systems as well as through conference presentations.

The Budget

The County is requesting $16,282,502 in MHSA funds for this Innovation over 5 years. Additionally, the County anticipates generating $5,441,206 in Medi-cal, FFP and Non-EPSDT funds, for a total of $21,723,708 for the five year project.

The County expects to use the funds for salaries for 16 Psychiatric Social Worker II's, 16 Community Workers, a Mental Health Program Manager I, a Mental Health Clinical Supervisor and a Clinical Psychologist II. The Clinical Psychologist will lead the evaluation.

Salaries and benefits in the amount of $16,406,035.30, (does not include the Clinical Psychologist salary and benefits since these are also designated as evaluation costs), represent 75.5% of the total budget.

The Clinical Psychologist/Evaluator salary and benefits in the amount of $754,672 for five years and represents about 3.5% of the total budget and appears to include evaluation costs for the project.

Administrative costs in the amount of $3,663,000 represents 16.8% of the total budget.

Training in the amount of $500,000 represents 2% of the budget and the one time cost associated with the purchase of 16 vehicles ($400,000) represents 1.8% of the budget.

The County reports that funds they are using for this project do not come from any AB 114 funds since they are planning on using FY 16/17 funds in the amount of $8,300,000, $3,100,000 from FY 19/20 and $1,080,000 from FY 20/21.

The County may wish to identify how it will support this project for costs that may exceed the time limitation or if this program is successful, how it will sustain it, or if they have a contingency if revenue projections are not met.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the County must receive and inform the MHSOAC of approval from the Los Angeles County Board of Supervisors before any Innovation Funds can be spent.

References

https://www.americanbar.org/content/dam/aba/administrative/law_aging/PublicGuardianshipAfter25YearsIntheBestInterestofIncapacitatedPeople.authcheckdam.pdf

https://www.scpr.org/news/2017/08/08/74469/conservatorship/

http://file.lacounty.gov/SDSInter/lac/1036162_2018-19RecommendedBudgetVolumeI.PDF3.

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-09/los-angeles-county-innovation-project-ongoing-focused-support-improve-recovery

LACDMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

MHSA Innovation 9 Project: Ongoing Focused Support To Improve Recovery Rates for Conservatees Living in the Community

Contextual Factors Supporting the Need in Los Angeles County

Individuals conserved by the Public Guardian frequently often have only their Conservator/PG deputy involved in their life and care decisions and have often receive only elemental, stabilization-focused mental health services. The expectation of recovery from mental illness for conservatees has under-paced the rest of the public mental health system in Los Angeles County. Recovery from mental illness must be an expectation for conservatees, just as it is for other clients treated in the public sector.

Over the last year the Los Angeles County Board of Supervisors has initiated motions directing the Los Angeles County Department of Mental Health (LACDMH) to streamline the process for and enhance services to individuals with a mental illness who meet the criteria for conservatorship, as well as increase access to all levels of care as they are needed, including at the level of Lanterman Petris Short (LPS) conservatorship. An essential step to implementing these motions is to enhance the array of recovery-focused mental health services received by conservatees that is focused not merely on maintenance but on recovery. LACDMH is seeking approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to implement this pilot project.

The Innovation

The Los Angeles County Department of Mental Health will implement a program to increase conservatees' support and access to an array of services in their community in order to increase autonomy, improved quality of life and community integration. Two teams per each of the 8 service areas (SA) will be composed of a clinician and a peer mentor. Each of the sixteen teams will provide support, case management and consultative services for a caseload of 50 clients conserved through the PG, who are living in the community/B&C facility (approximately 800 individuals at this time) and not within the confines of a locked facility. These two person teams will be embedded within existing mental health clinics and will serve as PG experts or champions for clients on conservatorships. There will be regular treatment team meetings and in-service trainings for clinicians, peer mentors, families, B&C operator/staff and the PG to create shared goals and treatment plans for clients on conservatorship.

Throughout the five (5) year implementation of this project, the Department will focus on learning, training and collaboration with the PG, including addressing barriers to implementation, identify and promote successful strategies throughout the system and use outcomes and evaluation to inform shared learning. Successful strategies and training will be evaluated and tracked, in order to better inform the project. LACDMH will continue to seek input from Stakeholder involvement and identify areas most helpful and beneficial in informing systems where the PG office is not directly connected to the mental health system and communication and collaboration prove to be of greater challenge.

The roles of the clinician and peer mentor on each team will expand in order to address the needs of the conservatees and create greater connection between the public guardian and treatment team. Peer staff will help promote the expectation of recovery by instilling hope through appropriate sharing of their own lived experience, modeling self-care, skill buiding and teaching ways to overcome adversity. Peer staff will mentor clients on strategies to navigate the mental health system and most importantly use their lived experience to develop "empathic relationships" with conservatees. Combined in-service trainings

across the teams and PG will provide a seamless understanding of all systems and services that impact conservatees. Training in the board and care facilities where conservatees reside will also be an important component of this project, to ensure these facilities are providing adequate support and utilizing the recovery model for these consumers.

Primary Purpose and Qualification as an Innovation Project

The primary purpose of this Innovation Project is to increase access to mental health care and support and to promote early detection of mental health symptoms or predict the onset of mental illness. This project proposes a new approach to overall public mental health service delivery.

Target Population

The focal population or intended beneficiaries for this project are adults on LPS conservatorships, from diverse cultural backgrounds, living throughout the communities of LA County and who are conserved through the Public Guardian's Office. All clients on conservatorships placed in LAC will initially reside within B&C facilities, per the PG's Office

Components of Ongoing Focused Support for Conservatees

1. Each conservatee, in conjunction with the PG consent to treatment, must voluntarily agree to be assigned to a clinic-based treatment team augmented by a clinician and a peer mentor funded by this INN project. The peer mentor and clinician will become the experts will assist the client with mental health support in their Board and Care (B&C) facility and in collaboration with the PG will connect the client to outpatient mental health services and join the treatment team and integrative activities throughout the system.
2. Guided by the principles of the recovery model, this team will provide ongoing support and advocacy as well as deliver mental health services.
3. Clinicians and peer mentors will develop partnerships with the PG conservators and other supportive programs in order to promote a culture of healing and recovery. The ideal is to bridge purposeful connection and training between the team and the PG in order to address concerns in real time, improve services that impact conservatees, and prevent vulnerable consumers from returning to locked facilities and assuring services needed are accessible.

How the Project Meets the Values of MHSA

The Los Angeles County Department of Mental Health understands the importance of MHSA roots and core values when planning for services, and in developing this project, has incorporated principles and practices of recovery for mental health consumer as the pinnacle of this project, including:

Community Collaboration: This project places particular emphasis on the concept of community collaboration. The emphasis on collaboration is apparent, as conservatees and their treatment teams work together with other community organizations involved in the care of the conservatees to meet treatment needs and goals. This collaboration will avoid duplication of services and improve a comprehensive understanding of the conservatee and their specific plan.

Service Integration: The project will also have a focus on service integration across all client care. Conservatees will have increased access to all the resources available in the community including health,

housing, employment and mental health services in a complete, informed and synchronized manner. This innovative approach will also place greater emphasis on communication between service delivery providers, the team and the PG office. At the same time, clinical advocates and peer mentors will help conservatees by increasing cooperation and sensitivity to their needs.

Focus on Recovery, Resilience and Wellness: This project will promote consumer/peer operated services to facilitate the recovery of conservatees where peer mentors become key players as they offer unique help learned through first-hand experience. Peers will provide ongoing support while encouraging self-responsibility, empowerment and greater autonomy. Empowering conservatees to move forward in the recovery and realize wellbeing and acknowledge their resilience, is the ultimate goal of intensive efforts in the area of service integration and collaboration. This project encourages increasing independence of conservatees, through collaborative care across systems, ensuring the sustainability of this level of autonomy and consideration of release from the conservatorship.

Client and Family Driven: This project is an ongoing effort to create meaningful roles for peer support specialists in the treatment of clients with serious mental illness. In this case, the inclusion of peer support specialists as treatment team members speaks to the commitment to involving peers in improving the treatment and life outcomes of conservatees. Family members often play a key role in the recovery process and will be included, as appropriate, in supporting the client's recovery.

Overall Goals

1. Optimize integration paths into community-based care and living for conservatees.
2. Optimize the development and maintenance of significant relationships and social and community connections, including family connections where appropriate.
3. Improve communication and collaboration on recovery strategies between the PG, conservatees and their treatment teams.
4. Improve communications with Board and Care facilities and the PG through the provision of trainings, offering support groups, consultation services and cross training between PG and treatment team.
5. Improve long-term treatment outcomes of conservatees as it is hoped will be evidenced through better health outcomes, decreased days within inpatient psychiatric facilities and consistent and collaborative engagement with the mental health system.
6. Aid conservatees in understanding and managing their illness, increasing autonomy, self-efficacy and quality of life. Facilitate conservatees, in tandem with the PG, to secure and maintain living arrangements under the least restrictive conditions.
7. Decrease the length of time a conservatorship is necessary, and eventually transition off, while remaining connected to their community support team.
8. Promote interagency collaboration related to mental health services.
9. Create true collaboration in which the clinical advocate/peer mentor teams will be working together with the conservatees, the PG family, family members and other community agencies involved, in order to address existing gaps in treatment access and delivery.
10. Empower clients to have meaningful participation in their treatment, increasing their self-efficacy, quality of life and ultimately a clinically appropriate level of independence.

Overarching Learning Questions and Evaluation

1. Does a recovery based advocacy approach help improve client quality of life?
   - Quarterly administration of an instrument that measures well-being, as defined by social support, satisfaction with living arrangements, living arrangement status and meaningful use of time. LAC DMH is in the process of procuring such an instrument via a solicitation process that would be used systemwide.

2. Are rates of recidivism and incarceration reduced as a result of these services?
   - Hospitalization, incarceration and IMD use will be tracked for conservatees served by this project and compared to LPS conservatees not receiving services as part of this project.

3. Did utilization of outpatient mental health services increase?
   - An annual evaluation with assess length of time conservatees are engaged and connected to mental health services and the rate of accessing services, as compared to those conservatees without community support.

4. Was the average length of conservatorship reduced?
   - An annual assessment will collect data on the average length of LACDMH conservators in the community support project, as compared to those conservatees not in the program.

5. Was a secondary gain of basic health outcomes realized, due to the support and advocacy of the community support team?
   - Basic health measures will be measured quarterly for positive changes after initiation of participation to identify any secondary impact on improved client health outcomes. (I.e. Blood pressure, weight, blood sugar levels, triglyceride levels, BMI, etc.)

Stakeholder Involvement

This proposal was developed and vetted through the Innovation pipeline workgroup, with specific subject matter experts, including the Chief of the Public Guardians Office within the LAC DMH. The pipeline group has grown to 45 individuals and is open to others joining the group. The pipeline workgroup is comprised of the following constituencies:
Peers, peer services, the mental health commission, contracted agencies, veterans, transitional age youth services, family members, older adult services, education and employment, housing, emergency services, directly operated agencies, LGBTQ population and services, Asian Pacific Islander population, African African-American population, Latino population, Children's services, Schools, NAMI, Service Area Advisory Committee members, Urgent Care Centers, community consultants/activists and ACHSA.

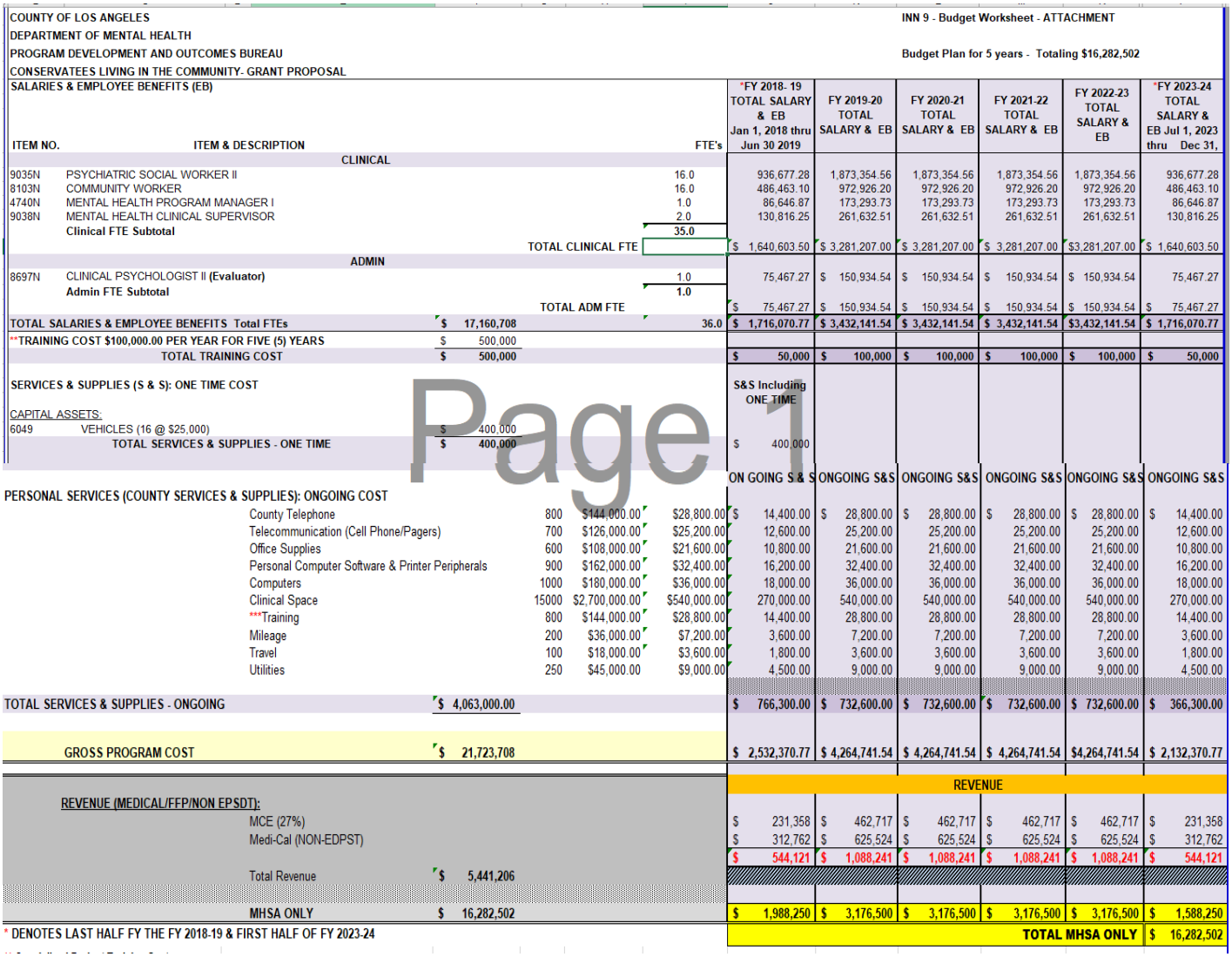
Presentations were made to the Department's stakeholder group, the System's Leadership Team (SLT) in January, April and June of 2018, and generated useful feedback and suggestions. These discussions intended to encourage participation and gain input into the Pipeline group, as well as share the posted AB 114 INN proposed spending plan (posted 03/23/2018). This plan was re-posted on May 25, 2018. No additional public comments were received.

The INN Team presented to the Underserved Cultural Communities (UsCC) group on May 14, 2018 and at the Cultural Competency Committee meeting on June 13, 2018.

The Los Angeles County Board of Supervisors adopted this project, along with other AB 114 Innovation projects, at its June 6, 2018 meeting. This project represents a priority for the Board of Supervisors. This project, along with other AB 114 Innovation projects, were presented to the Mental Health Commission on June 28, 2018. The Commission supported the projects and had one of its Commissioners regularly attend Innovation Pipeline workgroup meetings as these projects were developed and vetted.

Budget

$16,282,502 over five (5) fiscal years, starting mid-year in FY 2018-19.



COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT AND OUTCOMES BUREAU
CONSERVATEES LIVING IN THE COMMUNITY- GRANT PROPOSAL

INN 9 - Budget Worksheet - ATTACHMENT

Budget Plan for 5 years - Totaling $16,282,502

ITEM NO.	ITEM & DESCRIPTION			FTE's	*FY 2018- 19 TOTAL SALARY & EB Jan 1, 2018 thru Jun 30 2019	FY 2019-20 TOTAL SALARY & EB	FY 2020-21 TOTAL SALARY & EB	FY 2021-22 TOTAL SALARY & EB	FY 2022-23 TOTAL SALARY & EB	*FY 2023-24 TOTAL SALARY & EB Jul 1, 2023 thru Dec 31,
	SALARIES & EMPLOYEE BENEFITS (EB)									
	CLINICAL									
9035N	PSYCHIATRIC SOCIAL WORKER II			16.0	936,677.28	1,873,354.56	1,873,354.56	1,873,354.56	1,873,354.56	936,677.28
8103N	COMMUNITY WORKER			16.0	486,463.10	972,926.20	972,926.20	972,926.20	972,926.20	486,463.10
4740N	MENTAL HEALTH PROGRAM MANAGER I			1.0	86,646.87	173,293.73	173,293.73	173,293.73	173,293.73	86,646.87
9038N	MENTAL HEALTH CLINICAL SUPERVISOR			2.0	130,816.25	261,632.51	261,632.51	261,632.51	261,632.51	130,816.25
	Clinical FTE Subtotal			35.0						
			TOTAL CLINICAL FTE		$ 1,640,603.50	$ 3,281,207.00	$ 3,281,207.00	$ 3,281,207.00	$3,281,207.00	$ 1,640,603.50
	ADMIN									
8697N	CLINICAL PSYCHOLOGIST II **(Evaluator)**			1.0	75,467.27	$ 150,934.54	$ 150,934.54	$ 150,934.54	$ 150,934.54	75,467.27
	Admin FTE Subtotal			1.0						
			TOTAL ADM FTE		$ 75,467.27	$ 150,934.54	$ 150,934.54	$ 150,934.54	$ 150,934.54	$ 75,467.27
	TOTAL SALARIES & EMPLOYEE BENEFITS Total FTEs	$	17,160,708	36.0	$ 1,716,070.77	$ 3,432,141.54	$ 3,432,141.54	$ 3,432,141.54	$3,432,141.54	$ 1,716,070.77
	****TRAINING COST $100,000.00 PER YEAR FOR FIVE (5) YEARS**	$	500,000							
	TOTAL TRAINING COST	$	500,000		$ 50,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 50,000
	SERVICES & SUPPLIES (S & S): ONE TIME COST				S&S Including ONE TIME					
	CAPITAL ASSETS:									
6049	VEHICLES (16 @ $25,000)	$	400,000							
	TOTAL SERVICES & SUPPLIES - ONE TIME	$	400,000		$ 400,000					
					ON GOING S & S	ONGOING S&S	ONGOING S&S	ONGOING S&S	ONGOING S&S	ONGOING S&S
	PERSONAL SERVICES (COUNTY SERVICES & SUPPLIES): ONGOING COST									
	County Telephone		800 $144,000.00	$28,800.00	$ 14,400.00	$ 28,800.00	$ 28,800.00	$ 28,800.00	$ 28,800.00	$ 14,400.00
	Telecommunication (Cell Phone/Pagers)		700 $126,000.00	$25,200.00	12,600.00	25,200.00	25,200.00	25,200.00	25,200.00	12,600.00
	Office Supplies		600 $108,000.00	$21,600.00	10,800.00	21,600.00	21,600.00	21,600.00	21,600.00	10,800.00
	Personal Computer Software & Printer Peripherals		900 $162,000.00	$32,400.00	16,200.00	32,400.00	32,400.00	32,400.00	32,400.00	16,200.00
	Computers		1000 $180,000.00	$36,000.00	18,000.00	36,000.00	36,000.00	36,000.00	36,000.00	18,000.00
	Clinical Space		15000 $2,700,000.00	$540,000.00	270,000.00	540,000.00	540,000.00	540,000.00	540,000.00	270,000.00
	***Training		800 $144,000.00	$28,800.00	14,400.00	28,800.00	28,800.00	28,800.00	28,800.00	14,400.00
	Mileage		200 $36,000.00	$7,200.00	3,600.00	7,200.00	7,200.00	7,200.00	7,200.00	3,600.00
	Travel		100 $18,000.00	$3,600.00	1,800.00	3,600.00	3,600.00	3,600.00	3,600.00	1,800.00
	Utilities		250 $45,000.00	$9,000.00	4,500.00	9,000.00	9,000.00	9,000.00	9,000.00	4,500.00
	TOTAL SERVICES & SUPPLIES - ONGOING	$	4,063,000.00		$ 766,300.00	$ 732,600.00	$ 732,600.00	$ 732,600.00	$ 732,600.00	$ 366,300.00
	GROSS PROGRAM COST	$	21,723,708		$ 2,532,370.77	$ 4,264,741.54	$ 4,264,741.54	$ 4,264,741.54	$4,264,741.54	$ 2,132,370.77
					REVENUE					
	REVENUE (MEDICAL/FFP/NON EPSDT):									
	MCE (27%)				$ 231,358	$ 462,717	$ 462,717	$ 462,717	$ 462,717	$ 231,358
	Medi-Cal (NON-EDPST)				$ 312,762	$ 625,524	$ 625,524	$ 625,524	$ 625,524	$ 312,762
					$ 544,121	$ 1,088,241	$ 1,088,241	$ 1,088,241	$ 1,088,241	$ 544,121
	Total Revenue	$	5,441,206							
	MHSA ONLY	$	16,282,502		$ 1,988,250	$ 3,176,500	$ 3,176,500	$ 3,176,500	$ 3,176,500	$ 1,588,250
	* DENOTES LAST HALF FY THE FY 2018-19 & FIRST HALF OF FY 2023-24								**TOTAL MHSA ONLY**	$ 16,282,502

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - LOS ANGELES

Innovation (INN) Project Name:	**Therapeutic Transportation**
Total INN Funding Requested:	**$18,342,400**
Duration of Innovative Project:	**Three (3) Years**

Review History:

Approved by the County Board of Supervisors:	Pending MHSOAC approval*
County submitted INN Project:	September 6, 2018
MHSOAC consideration of INN Project:	September 27, 2018

**This innovation plan was included as part of the County's AB 114 Reversion Plan and was adopted by the Board of Supervisors on June 6, 2018.*

Project Introduction:

Los Angeles County proposes to utilize equipped vans staffed with mental health professionals to provide transportation to consumers on involuntary psychiatric holds to the psychiatric hospital. Staff transporting consumers will consist of a psychiatric social worker, a mental health counselor/RN, and a peer support specialist (hired as community workers). It is the County's hope that this approach will lessen the transportation wait time for consumers who are medically stable and cooperative. The County states that outfitted vans may also help to reduce the stigma and trauma associated with hospital transport as consumers are typically transported via ambulance or accompanied by law enforcement.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one (1) of the four (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing. The County states this innovation project meets the primary purpose of increasing the access and quality of mental health services.

The Need

The County states that many underserved groups are reluctant to use mental health services especially when their first introduction to this service is through a crisis transport. The County reports that traditional transportation to a psychiatric facility are by either an ambulance or a police car. They indicate that this perpetuates the stigma of mental health and exacerbates the trauma of a mental health crisis as well as has the appearance that a crime, necessitating law enforcement involvement, has been committed.

The County also states that psychiatric transports that are performed by law enforcement require that the officer remain with the client until the client is admitted to the hospital or crisis care unit. Because of the long wait times in an emergency room a logistical burden on the County's police force is created. In 2011, it was reported that 54% of the psychiatric admissions were brought to the hospital by law enforcement and 9% of the psychiatric admission were brought in by the Department of Mental Health. In 2017, the Los Angeles Daily News reported that between the years 2010 and 2015, service calls related to mental health interactions were made to the Sheriff's Department and increased 54%, from 11,660 to 18,061. The County also states that when a psychiatric emergency call is made to them, there is often a 5 - 6 hour wait for an ambulance or other transport to a hospital.

The Response

To mitigate the stigma associated with being transported by either law enforcement or an ambulance, to address the exacerbation of a mental health crisis by long wait times or restrained transport and to free up law enforcement for other public matters, the County is proposing to establish Therapeutic Transports (TT). These transports will be conducted in unidentified/unmarked vans, staffed with a multidisciplinary transport team.

Los Angeles asserts this is innovative due to the "introduction of an improved mode of transportation and therapeutic support for clients on involuntary holds". County states this project would provide immediate services to consumers in crisis in an effort to begin the healing and recovery process. In addition, the County states they are different than similar programs operating in other Counties due to the addition of the peer component.

The County proposes to have ten (10) vans and four (4) transport teams per Supervisorial District in the County, allowing two (2) vans for each of the five (5) Supervisorial Districts (20 teams in total). Vans will be modified to be more clinically appropriate. **County may**

wish to provide information on how these vans will be modified, including the ability to provide supportive services and offer Telepsychiatry.

All teams, regardless of shift worked, will consist of three (3) members: a mental health clinician (hired as a Psychiatric Social Worker II), a Mental Health Counselor/RN; and a Peer Support Specialist (hired as Community Workers). The teams that are on-duty will available daily from 10:00am to 8:30pm to transport clients who are non-combative, cooperative, and have received medical clearance.

The teams will also collaborate with the hospital staff and communicate what mental health services are available for the clients, provide information that will enable the hospital to "establish services or make contact with the appropriate providers early on or establish an effective treatment and discharge plan for the client during hospitalization (page 2). Additionally, teams will also work with families to provide support and support of consumers.

During the transport, the team will work with the client to explain what is happening, what the process will be, initiate case management and will remain with the client until hospital admission has been completed. A critical component to this team is that this will take place in the presence of the peer specialist. The County believes that the peer specialist is vital in helping to facilitate a stronger connection with the client and establish trust. **Although the County states the team will be responsible for the driving of the van, it is recommended that the Peer Support Specialist remain connected with the client and not be responsible for driving the van.**

The County may wish to elaborate on whether the vans will be modified to allow transport of a physically disabled person who may utilize a wheelchair.

The County indicates that county employees are currently prohibited from transporting clients. Given that the County is in the process of revising this policy (page 2-3), the County may wish to update the Commission on the status of that revision and how its timing will affect the startup of this Innovation, if at all. In the event this policy is not approved by the County Council, the County may need to discuss a contingency plan.

<u>The Community Planning Process</u>

The County indicates that the planning process for this innovation project began in December 2017 with the development of an innovation pipeline group. This group provided an INN feedback form and INN guidelines. The pipeline group has met eight (8) times in 2018 (as of date of the writing of this proposal) and 30 proposals were submitted. Seven proposals did not meet the requirements for Innovation, 2 proposals were forwarded to veterans groups, six (6) proposals were referred for Prevention and Early Intervention services. Some proposals were combined with others. Ultimately there were three (3) proposals that addressed the issues of conservatees.

These were presented to the System Leadership Team in January and April 2018 and feedback from these meetings was incorporated into the development of this plan. This project was also shared with the Client Advisory Board, The Peer Resources Center, The

disability underserved Cultural Community Group, Services Area Advisory Chairs, NAMI chairs, and Program Manager III;'s throughout the County. The Underserved Cultural Communities and the Cultural Competency Committees had this plan presented to them on May 14 and June 13, 2018, respectively and presentations to the subcommittees is scheduled.

This Innovation project was shared with MHSOAC stakeholders July 5, 2018. No comments of opposition or support have been received to date. This innovation project was originally submitted in the amount of $9,525,788 with a request to purchase five (5) vans and utilizing ten (10) teams. The County decided to increase the request to $18,342,400 in order to purchase additional vans and additional teams. As a result of the change in project budget, the County is currently in its second public comment period. If any feedback is received during the second public comment period, the County will provide feedback on changes made to this innovation project.

The County may wish to explain how this plan was initially identified or what stakeholder group initially provided it.

Learning Objectives and Evaluation

Los Angeles County plans on implementing a therapeutic transportation (TT) project as a new method of meeting the needs of individuals who are on an involuntary hold. Specifically, the County will target Los Angeles County residents that are placed on non-voluntary psychiatric holds by the Los Angeles County Department of Mental Health Psychiatric Mobile Response Team (LACDMH PMRT). Through the project, the County hopes to determine whether or not the TT approach to meeting clients on involuntary holds will lead to a number of different outcomes with the integration of peers into PMRT teams. The County estimates they will serve and transport approximately 11,000 clients annually.

To guide their project, Los Angeles County has identified six main learning questions:

1. Will PMRT teams be more efficient in responding to a greater number of field calls with the implementation of TT teams?
2. Will there be a decrease in adverse events for clients during the waits for TT transport to hospitals, as compared to alternate forms of transportation?
3. Will wait times be decreased between the written hold and transportation arrival, based on the introduction of TT teams?
    a. How will this impact the number of requests to alternate forms of transportation?
4. Will utilizing peer support staff on the team during transport improve personal empowerment and buffer the negative impacts during the hold and transport process?
5. Will the length of hospitalization days decrease with positive effects of therapeutically transporting, and providing linkage throughout the process from TT arrival until the client has completed hospital admission?
6. Will TT recipients obtain more timely and consistent connection to services?

In addition to these learning questions, Los Angeles County has identified several intended outcomes: (1) improved response times; (2) improved access to care; (3) decreased hospital stays; (4) decreased client trauma; and (5) enhanced support and empowerment of clients and their needs. **The County may wish to clarify how trauma and adverse events are being defined for the purposes of meeting these outcomes.**

In order to gather the data necessary to measure these outcomes, the County will track the number of field calls, times between the receipt of calls and arrival of TT team, and length of hospitalizations, on a quarterly basis. Additionally, the County will develop a questionnaire that TT clients will complete relative to their overall experiences with the approach and any impact that peer involvement had on their experience (**see pgs. 6-7 of County plan**). These data will be compared to the same data from alternate forms of transportation.

The County states that an in-house psychologist and analyst will support data collection and analysis, as well as the completion of the final evaluation report. Results and lessons learned from the Therapeutic Transportation project will be shared with local providers and counties across the state through provider meetings, learning seminars and workshops, as well as during conference presentations.

The Budget

Los Angeles County is estimating the gross amount of this innovation project will be $30,451,337; however, the County is seeking approval to use MHSA innovation funds in the amount of $18,342,400 over a three (3) year project duration. The County also anticipates receiving reimbursements totaling $10,625,156 from a combination of Medi-Cal, FFP, and Non-EPSDT funds. **The County may wish to explain if there is a contingency plan in place if anticipated reimbursements are not received.** The County asserts this innovation project is separate from any current SB82 triage programs operating in their County at this time.

A total of $24,401,787 (80.1% of the total plan cost) is estimated for the salaries and benefits for 71 staff.

The County states they will use these funds for the salaries of the following staff:

- Twenty (20) Psychiatric Social Worker II’s
- Twenty (20) Community Workers (Peer Specialists)
- Twenty (20) Mental Health Counselors/RN
- Four (4) Mental Health Clinical Supervisors
- One (1) Mental Health Program Manager II
- One (1) Clinical Psychologist II (will lead the evaluation component)
- Four (4) Clerk Typists (will work with each of the Clinical Supervisors)
- One (1) Secretary III (will work with Program Manager II)

The County reports the following additional costs for this project:

- $1,500,000 (4.9% of the total plan cost) will used to purchase and modify ten (10) vans, used to transport the Therapeutic Team and the client;
- $100,000 (.3% of the total plan cost) will be used for tele-psychiatry equipment in the vans;
- $175,000 (0.6% of the total plan cost) will be used for annual training, and
- $4,274,550 (14.0% of the total plan cost) will be used for county administrative costs.

In regards to the purchase of the ten (10) vans, Los Angeles states the outfitting of the vans will depreciate the cost of each of the vans by approximately $35,000 annually and by the project's end, the estimated value of the all ten (10 vans will be worth $45,000. Maintenance costs of the van have been included into the cost of the vans.

The County may wish to address the salary for the Analyst (member of the evaluation team), identified on page 8 of the project proposal. If, as the County reports, this position, along with the Clinical Psychologist position is a shared cost with other innovations, then the County may wish to identify what percent of salary is represented in this budget.

The County may wish to reconcile the salaries and benefits portion of the Innovation budget between the excel amounts and the amounts provided on the project plan. Additionally, County may wish to clarify the salary of the Clinical Psychologist II who will undertake the evaluation: budget sheet indicates salary will be $452,808 while budget narrative (pg. 11) indicates salary will be $171,285 for total project while the fiscal year amounts total $513,854.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations, however, if Innovation Project is approved, the MHSOAC must receive and inform the MHSOAC of this certification of approval from the Los Angeles County Board of Supervisors before any Innovation Funds can be spent.

References

https://www.dailynews.com/news/

https://pdfs.semanticscholar.org/presentation/8ee5/f011905beefd84e415324ae7876ca86f8c5a.pdf

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-09/los-angeles-county-innovation-projecttherapeutic-transportation-tt-september-27

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MHSA INNOVATION 7 PROJECT
THERAPEUTIC TRANSPORTATION

The Innovation

LACDMH proposes a countywide project to transform the County's approach to responding to individuals placed on an involuntary hold or at significant risk of being placed on a hold through engagement, support and recovery-focused interventions delivered using specially outfitted vans, staffed with mental health clinicians, mental health counselor, RNs (MHC, RN) and peer support specialists. Staff would offer a supportive and expedited response to transportation as well as initiate supportive case management in order to begin the healing and recovery from the exacerbation of mental health symptoms from the first point of contact. This mobile mental health van concept, modeled after the PAM (Psychiatric Emergency Response) ambulances of Stockholm, Sweden, provide supportive services delivered to individuals in crisis. Similar to the Sweden program, the LACDMH team will respond to the Psychiatric Mobile Response Team's (PMRT) request either to transport a client who is on a hold or to intervene on the streets to avoid the need for an involuntary hold. The team will provide a supportive and therapeutic environment consisting of a clinician, MHC, RN and peer support specialist as well as the capacity for tele-psychiatry services.

Through this project, LACDMH will introduce a therapeutic environment in the form of a specially outfitted van, a concept driven by community input and needs and a Board of Supervisor motion. Not only do we anticipate that this approach will shorten the wait time for an ambulance for medically stable, non-combative and cooperative individuals, therefore reducing the utilization of ambulance and law enforcement resources for 5150/5585 transportation, it will frontload the recovery process through a caring, non-restraining and supportive mobile environment. Ultimately, LACDMH anticipates, by changing the current transportation and engagement practices to a more consumer friendly and private, less traumatizing and less stigmatizing approach, this practice will frame and center the involuntary hospitalization process. TT will support clients and their families from the point of transportation to the hospital, as the first step toward recovery, contributing to increased consumer trust, reduced wait times to the hospital and reduced stigma. In the process of response, the teams may also serve to reduce the need for psychiatric hospitalizations.

Why the Need for Therapeutic Transportation in L.A. County

A motion was adopted by the Los Angeles County Board of Supervisors in 2017 to improve the standard of care for mentally ill individuals. The motion directed LACDMH to develop recommendations to adopt "humane treatment for those suffering from mental illness and are unwilling and/or incapable of accepting care." This proposed Innovation project was developed in partial response to that motion.

- **Volume:** Between PMRT and law enforcement response teams a total of 13,253 holds were written in LA County last year (11,817 5150s/1,436 5585s).
- **Long wait time for ambulances** that could potentially impact client and staff safety

- **The process of putting individuals in ambulances compromises one's dignity and rights, and the mere incident of transport via ambulance or law enforcement can make their mental health issues unwantedly visible to others in the neighborhood, aggravating the potential for trauma and stigma they may have already experienced within their community**
- **Potential as a more cost-effective approach for LAC, reducing time spent waiting for transport by law enforcement and other mental health professionals, allowing them to assist others in the community in need of crisis stabilization while TT handles the transport and linkage/admission process.** This innovation project proposes to have a response time of within one hour of the request, and to allow for the transport of clients who meet specified criteria placed on involuntary holds. LACDMH has revised it's policy regarding the transportation of clients in order to implement this project.

Innovation Criteria and Primary Purpose

This proposal qualifies as an Innovation Project, through the introduction of an improved mode of transportation and therapeutic support for clients on involuntary holds. The project approach introduces a new application to the mental health system of a promising community-driven practice and approach that has been successful in a non-mental health context or setting by way of utilizing peers, decreasing wait times, and reducing the effects of trauma on individuals. The primary purpose of the project is to increase access and the quality of mental health services to underserved, unengaged groups.

In response to community needs for greater efficiency, some states/counties are trying new pilot programs for alternative transportation; however, few agencies have developed an internal transportation team equipped with both multidisciplinary mental health professionals and peers. Based on the current practices of most agencies, alternative transportation utilization serves individuals who are 1) medically stable, 2) non-combative/violent and 3) cooperative with the involuntary hold process. Ultimately, the goal is for the agency initiating the 5150/5585 hold to make the assessment and decision on whether to use ambulance, law enforcement or the alternative TT team.

In reviewing a recent project in Alameda County, the major differences between the plans of LACDMH and Alameda were interpreted as follows:

- The higher demand and volume of clients proposed to serve due to size and population of LA County being so expansive, the implementation of TT would greatly alleviate the impact of using Law Enforcement and First Responders (due to already high demands in such a populated County)
- The use of peers on teams

How the Teams Will Operate

Teams will respond to requests from PMRT or ACCESS to transport clients who either have been placed on a hold and deemed safe for TT or at risk of being placed on a hold with the risk being mitigated by team intervention. During transport, the team will explain what has transpired, answer any questions the client may have, monitor vitals as indicated and consult and engage with tele-psych support as warranted, and with client consent, and assist with any urgent case management matters. The team or a team member

will remain with the client in the setting during transport and through admission completion. LACDMH anticipates that the addition of a peer on the team will allow for a stronger, more relatable connection of trust for the client, while allowing the clinician to communicate clinical impressions during transport and waiting, and the team to make calls, linkages, and appointments/cancellations necessary during their encounter.

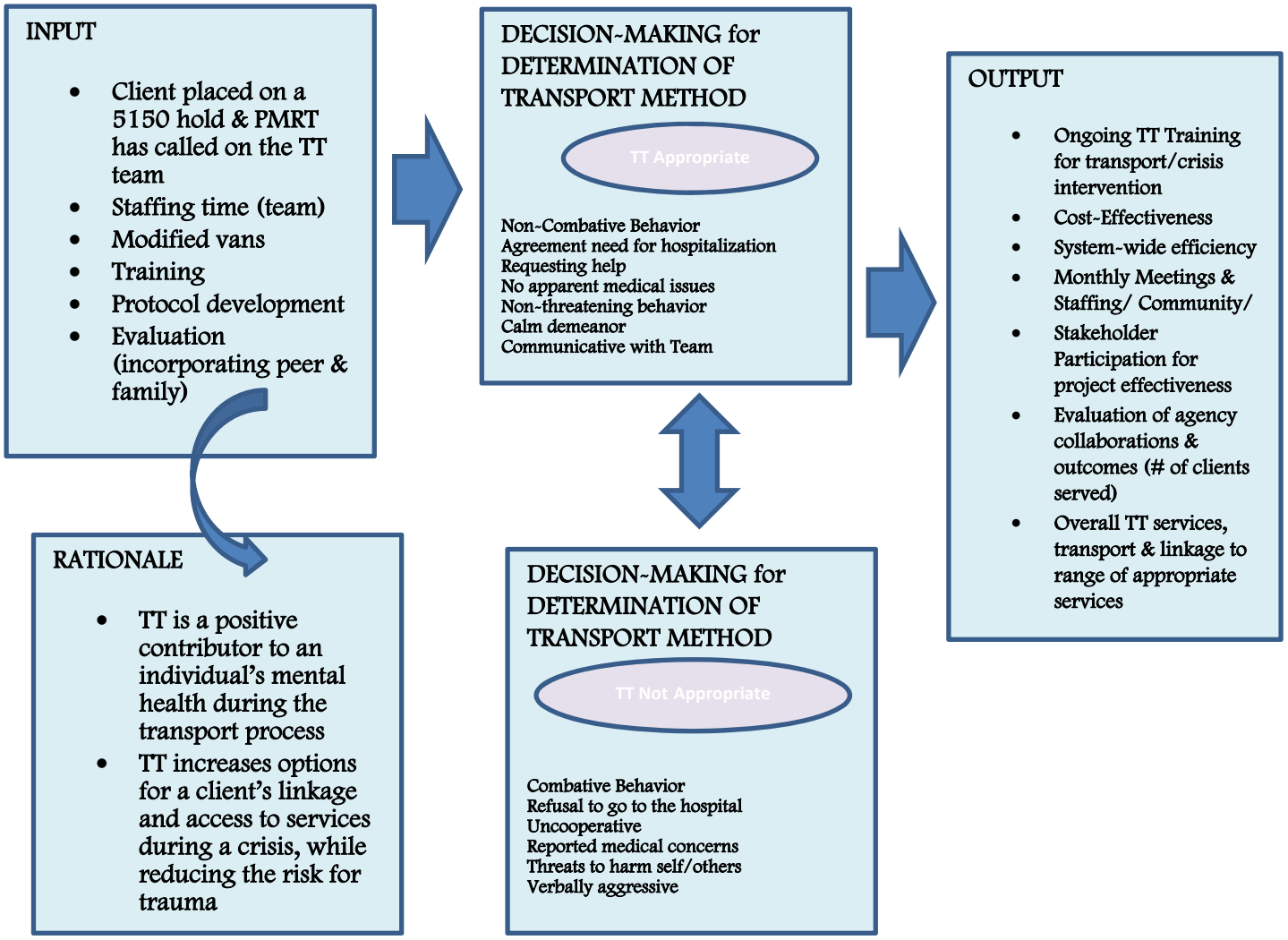
Each team would have the capacity to intervene and/or transport at least 3 individuals daily. Minimally each Supervisorial District (**SD**) TT would consist of two (2) vans and four (4) teams of three (3) members each. These teams will also be supported, trained and directed by 4.0 Mental Health Clinical Supervisors and 1.0 Mental Health Clinical Program Manager II. The protocol would be for this team to respond to transport requests of clients placed on a 5150/5585 deemed safe for transport and approved for inpatient hospital admission. This team, or at minimum, one member of the team would remain with the client until admission is complete, should the team have another request for transport.

We envision the hours of operation for the teams to be daily from 10:00 am to at least 8:30 pm., and consisting of two (2) teams of three (3) team members, per SD. LACDMH is comprised of five (5) SDs; therefore, each SD will be comprised of four (4) teams working ten (10) hour shifts, with two (2) teams working Sunday through Wednesday and the other teams, Wednesday through Saturday. Wednesdays will be ideal for TT staff meetings and in-service trainings, as all team members will overlap on that day. We anticipate the need is for ten (10) vans and seventy-one (71) staff, (Twelve (12) per SD, in addition to the five (5) supervisory staff, five (5) administrative support staff and one (1) evaluation staff.) for the successful implementation of this proposed pilot plan.

Capacity

It is projected the TT teams will transport 11,000 clients annually, with projected numbers lower in the initial six months with start-up, allowing for the PMRT to respond to a greater number of clients in need of their services.

LOGIC MODEL



How the Project Meets MHSA Values

The Los Angeles County Department of Mental Health understands the importance of MHSA roots and core values when planning for services, and in developing this project, has incorporated principles and practices of recovery for mental health consumer as the pinnacle of this project, including:

- **Cultural Competence:** Initiating the addition of a peer on a multidisciplinary transport team, will allow for a stronger connection and trust for the client, knowing this individual has a better understanding of consumer services and delivery. A concentrated effort will be made during the recruitment and hiring of the teams, to match the ethnic and cultural makeup of each individual SD. We anticipate the teams to be reflective of the cultural, ethnic and racial diversity of mental health consumers served in Los Angeles County.
- **Mental Health Care is Consumer and Family-Driven:** Planning for each consumer's individual needs on a customized basis will be the hallmark of this project, as it is critically important to

involve the consumer needs and their families during times of crisis, and to ease the worry of all parties involved during a client hold. In the event of transport, we envision the team explaining what has transpired and why, answer questions the client may have, and through client consent assist with any urgent case management matters.

- **Focus on Recovery, Resilience and Wellness:** Clients will have decreased levels of trauma and an increased level of support from the multidisciplinary transport team, allowing for a greater level of focus on their recovery, resilience and overall wellness during an acute occurrence. Through decreasing long wait times, as well as stress of restraints used during transport, clients will experience a greater level of support throughout the transport. Clients will be empowered through a new level of comfort to ask questions or contact providers and/or family to inform them of the current situation. The conversations during transport will focus around wellness, recovery, resilience and planning next steps for their journey ahead.
- **Service Integration:** Supported transport from point of initial contact until admission completion, will create a stronger connection of trust between client, professional, peer and community resources. The TT team, advocating for and connection to appropriate supports will decrease wait times and trauma, while increasing efficiencies across systems community-wide. The clinician will communicate clinical impressions during transport and waiting, the case manager will make calls, linkages, and appointments/cancellations necessary during their time together. The team or the peer team member will remain with the client through the admission process, to assure collaboration, plan and connection is solid.

Goals of This Project

In summary, TT would:

- Decrease wait time and improve response times for PMRT and transportation
- Provide opportunity for team to remain with client until admission is complete
- Provide services and supports throughout the transport process
- Decrease trauma throughout the hold and transport process
- Incorporate peer support staff on the team to allow better understanding of each situation and establish peer-to-peer support.
- Improve collaboration across systems and efficiency in connection to supportive services
- Decrease the average number of inpatient days for clients transported by the TT team, as compared to alternate forms of emergency transport

Overarching Learning Questions and Evaluation

1) Will PMRT teams be more efficient in responding to a greater number of field calls with the implementation of Therapeutic Transportation teams?
    a. A comparison made quarterly, as compared to the previous year, analyzing the request for calls in contrast to actual response calls
    b. Track and record the number of TT provided, per SD, on a quarterly basis

2) Will there be a decrease in adverse events for clients during the waits for TT transport to hospitals, as compared to alternate forms of transportation?
    a. All adverse events occurring for clients placed on holds and waiting for transport, will be tracked and reported on a quarterly basis
    b. A comparison will be made between events occurring while clients are waiting for TT, as opposed to individuals waiting for alternate forms of transportation
3) Will wait times be decreased between the written hold and transportation arrival, based on the introduction of the therapeutic transportation team, and how will this impact the number of requests for alternate forms of transportation?
    a. Track and report on a quarterly basis the length of time it takes TT to arrive to calls as compared to alternate forms of transportation.
    b. Analyze if alternate forms of transportation times are improving, as compared to previous reported wait times
    c. Track and report the number of TT, ambulance, law enforcement and other forms of transportation for clients on holds on a quarterly basis.
4) Will utilizing peer support staff on the team, and encouraging primary interaction between the peer and the client during transport improve personal empowerment and buffer the negative impacts that may otherwise affect trauma during the hold and transport process?
    a. Complete a questionnaire with all clients receiving TT regarding their experience and the impact by the addition of a peer on the team
5) Will the length of hospitalization days decrease with positive effects of therapeutically transporting (i.e., trusted, timely, professional interactions between transport team and client) as well as providing a compassionate presence, problem resolution, and providing linkage throughout the process from TT arrival until the client has completed hospital admission?
    a. Compare the number of days hospitalized after a 5150, between TT and alternate modes of transportation; determine if the correlation between transportation and number of days hospitalized is significant and contributes to a cost savings
6) Will TT recipients obtain more timely and consistent connection to services?
    a. Track and compare when appointments are made for clients receiving TT opposed to other forms of transport; track this through SRTS and IBHIS and report on a quarterly basis
    b. Track the rate at which clients receiving TT keep appointments, opposed to other forms of transport by capturing this information through SRTS and IBHIS; report on a quarterly basis

Stakeholder Involvement in Proposed Innovation Project

The Department utilized an Innovation Pipeline Workgroup to identify, develop and provide broad feedback into proposals. In addition, presentations on this project were made to the Department's System Leadership Team and to the Under-Served Cultural Communities (UsCC) group.

The only public comment received recommended increasing the number of teams as well as the infrastructure. LAC DMH acted on part of the recommendation, doubling the initially proposed program and adding 4 supervisors and an entry level program manager to ensure appropriate supervision and oversight.

Board of Supervisor and Mental Health Commission Endorsement

This project is in partial response to a Board motion. The Los Angeles County Board of Supervisors adopted this project, along with other AB 114 Innovation projects, at its June 6, 2018 meeting. This project, along with other AB 114 Innovation projects, were presented to the Mental Health Commission on June 28, 2018. The Commission supported the projects and had one of its Commissioners regularly attend Innovation Pipeline workgroup meetings as these projects were developed and vetted.

Budget

COUNTY OF LOS ANGELES — **INN 7 - Budget Worksheet - ATTACHMENT**
DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT AND OUTCOMES BUREAU — **MHSA 3 YEAR BUDGET PLAN - $ 9,525,788**
INNOVATION 7 (INN 7) - THERAPEUTIC TRANSPORTATION - GRANT PROPOSAL

SALARIES & EMPLOYEE BENEFITS (EB)				*FY 2018-19 TOTAL SALARY & EB Jan 1, 2019 thru Jun 30 2019	FY 2019-20 TOTAL SALARY & EB	FY 2020-21 TOTAL SALARY & EB	*FY 2021-22 TOTAL SALARY & EB Jul 1, 2021 thru Dec 31 2021
ITEM & DESCRIPTION							
CLINICAL							
ITEM NO.			**FTE's**				
9035N	PSYCHIATRIC SOCIAL WORKER II		20.0	$1,170,847	$ 2,341,693	$ 2,341,693	$1,170,847
8103N	COMMUNITY WORKER		20.0	$608,079	$ 1,216,158	$ 1,216,158	$608,079
5278N	MENTAL HEALTH COUNSELOR, RN		20.0	$1,705,515	$ 3,411,030	$ 3,411,030	$1,705,515
8697N	CLINICAL PSYCHOLOGIST II*		1.0	$75,468	$ 150,936	$ 150,936	$75,468
4741N	MENTAL HEALTH PROGRAM MANAGER II		1.0	$93,987	$ 187,974	$ 187,974	$93,987
9038N	MENTAL HEALTH CLINICAL SUPERVISOR		4.0	$261,633	$ 523,265	$ 523,265	$261,633
2214N	INTERMEDIATE TYPIST CLERK		4.0	$114,969	$ 229,939	$ 229,939	$114,969
2102N	SENIOR SECRETARY III		1.0	$36,467	$ 72,935	$ 72,935	$36,467
	Clinical FTE Subtotal		**71.0**				
TOTAL SALARIES & EMPLOYEE BENEFITS FTEs		**$ 24,401,787**	**71.0**	**$4,066,965**	**$ 8,133,929**	**$ 8,133,929**	**$4,066,965**
TOTAL CAPITAL ASSETS & SPECIALIZED TRAINING				**S&S Including ONE TIME**	**ONGOING S&S**	**ONGOING S&S**	**ONGOING S&S**
CAPITAL ASSETS:							
	VANS 10 @ $150,000.00 (One Time Cost)	1,500,000		$ 1,500,000			
	TELE-PSYCHIATRY EQUIPMENT 10 @$10,000 (One Time Cost	100,000.00		100,000			
*** SPECIALIZED ANNUAL TRAINING							
	3.5 @ $50,000.00 (1 per Fy)	175,000		50,000	50,000	50,000	25,000
TOTAL CAPITAL ASSETS & SPECIALIZED TRAINING		**$ 1,775,000**		**$ 1,650,000**	**$ 50,000**	**$ 50,000**	**$ 25,000**
SERVICES & SUPPLIES: ONGOING COST	*County Telephone*		800	*$ 28,400*	*$ 56,800*	*$ 56,800*	*$ 28,400*
	Telecommunication (Cell Phone/Pagers)		700	*$ 24,850*	*49,700*	*49,700*	*$ 24,850*
	Office Supplies		600	*$ 21,300*	*42,600*	*42,600*	*$ 21,300*
	Personal Computer Software		500	*$ 17,750*	*35,500*	*35,500*	*$ 17,750*
	Computers		1000	*$ 35,500*	*71,000*	*71,000*	*$ 35,500*
	Printer/Peripherals		400	*$ 14,200*	*28,400*	*28,400*	*$ 14,200*
	*Space **(Clinical/Clerical)***		15000/11000	*$ 522,500*	*1,045,000*	*1,045,000*	*$ 522,500*
	** *Training*		800	*$ 28,400*	*56,800*	*56,800*	*$ 28,400*
	Utilities		250	*$ 8,875*	*17,750*	*17,750*	*$ 8,875*
	Mileage		200	*$ 7,100*	*14,200*	*14,200*	*$ 7,100*
	Travel		100	*$ 3,550*	*7,100*	*7,100*	*$ 3,550*
TOTAL SERVICES & SUPPLIES - ONGOING COST		**$ 4,274,550**		**$ 712,425**	**$ 1,424,850**	**$ 1,424,850**	**$ 712,425**
GROSS PROGRAM COST		**$ 30,451,337**		**$ 6,429,390**	**$ 9,608,779**	**$ 9,608,779**	**$ 4,804,390**
							REVENUE
REVENUE (MEDICAL/FFP/NON EPSDT):		**$ 9,522,713**					
	MCE @ 27%			$ 1,735,935	$ 2,594,370	$ 2,594,370	$ 1,297,185
	Non-EPSDT			448,639	594,778	594,778	297,389
TOTAL REVENUE				**$ 1,549,843**	**$ 3,189,148**	**$ 3,189,148**	**$ 1,594,574**
NET PROGRAM COST		**$ 20,928,625**		**$ 4,879,547**	**$ 6,419,631**	**$ 6,419,631**	**$ 3,209,816**
9911 MHSA ONLY						TOTAL MHSA COST	**$ 20,928,625**

* DENOTES LAST HALF OF FY 2018-19 & FIRST HALF OF FY 2021-22
** Mandatory staff training *** Specialized Project Training Cost

Back to Agenda

AGENDA ITEM 4

Information

September 27, 2018 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures (7): (1) The Motions Summary from the August 23, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard (4) Presentation Guidelines; (5) Calendar of Commission activities; (6) Department of Health Care Services Revenue and Expenditure Reports status update; (7) Legislative Report to the Commission

Handouts: None.

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
August 23, 2018

Motion #: 1

Date: August 23, 2018 **Time:** 9:48 AM

Motion:

The Commission approves the July 26, 2018 Meeting Minutes as corrected.

Commissioner making motion: Commissioner Alvarez
Commissioner seconding motion: Vice-Chair Aslami-Tamplen

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☐	☐	☒
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☒	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☐	☐	☒
9. Commissioner Gordon	☐	☐	☒
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

Motion #: 2

Date: August 23, 2018 **Time:** 11:09 AM

Motion:

The MHSOAC supports Senate Bill 192 (Beall).

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☐	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☒	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☐	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 3

Date: August 23, 2018 **Time:** 11:10 AM

Motion:

The MHSOAC supports Senate Bill 1004 (Wiener and Moorlach).

Commissioner making motion: Commissioner Gordon
Commissioner seconding motion: Commissioner Madrigal-Weiss

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☒
2. Commissioner Anthony	☐	☒	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☐	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☒	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☐	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 4

Date: August 23, 2018 **Time:** 12:08 PM

Motion:

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

> **Name:** Micro-Innovation Grant Activities for Increasing Latino Engagement
> **Amount:** $1,240,000
> **Project Length:** Three (3) Years

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Alvarez

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☐	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☒	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 5

Date: August 23, 2018 **Time:** 12:09 PM

Motion:

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

> **Name:** Transportation Coaching by Wellness Navigators
> **Amount:** $1,234,000
> **Project Length:** Three (3) Years

Commissioner making motion: Vice-Chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Gordon

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☐	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☒	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 6

Date: August 23, 2018 **Time:** 3:06 PM

Motion:

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

Name: *headspace*
Amount: $14,960,943
Project Length: Four (4) Years

Commissioner making motion: Commissioner Beall
Commissioner seconding motion: Vice-Chair Aslami-Tamplen

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☒	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☐	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 7

Date: August 23, 2018 **Time:** 3:46 PM

Motion:

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

Name: Accessible Depression and Anxiety Postpartum Treatment (ADAPT)
Amount: $4,773,040
Project Length: Five (5) Years

Commissioner making motion: Commissioner Alvarez
Commissioner seconding motion: Commissioner Anthony

Motion carried 7 yes, 0 no, 0 abstain, and 1 recusal (Madrigal-Weiss) per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☒	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☐	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 8

Date: August 23, 2018 **Time:** 4:12 PM

Motion:

The MHSOAC approves San Luis Obispo County's Innovation Project, as follows:

Name: 3-by-3 Developmental Screening Partnership Parents & Pediatric Practices
Amount: $859,998
Project Length: Four (4) Years

Commissioner making motion: Commissioner Madrigal-Weiss
Commissioner seconding motion: Commissioner Anthony

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☒	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☐	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

Motion #: 9

Date: August 23, 2018 **Time:** 4:13 PM

Motion:

The MHSOAC approves San Luis Obispo County's Innovation Project, as follows:

Name: Affirming Cultural Competence Education & Provider Training: Offering Innovative Solutions to Increase LGBTQ Mental Health Care Access (SLO ACCEPTance)
Amount: $554,729
Project Length: Four (4) Years

Commissioner making motion: Vice-Chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Madrigal-Weiss

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Ashbeck	☐	☐	☐
4. Commissioner Beall	☒	☐	☐
5. Commissioner Brown	☐	☐	☐
6. Commissioner Bunch	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐
8. Commissioner Danovitch	☐	☐	☐
9. Commissioner Gordon	☒	☐	☐
10. Commissioner Madrigal-Weiss	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Aslami-Tamplen	☒	☐	☐
15. Chair Boyd	☒	☐	☐

Back to Agenda

MHSOAC Evaluation Dashboard September 2018

(updated 09/06/18)

Current MHSOAC Evaluation Contracts & Deliverables

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff: Brandon McMillen & Rachel Heffley

Active Dates: 10/31/16 – 7/27/19

Total Contract Amount: $1,000,000

Total Spent: ***$685,000***

Objective: To make data from reports on programs funded under the Mental Health Services Act, available to the public via a Visualization Portal. The portal will provide transparency through the publication of information & statistics to various stakeholders. Resources will be provided to allow MHSOAC staff to evaluate, merge, clean, & link all relevant datasets; develop processes & standards for data management; identify & configure analytics & visualizations for publication on the MHSOAC public website; & manage the publication of data to the open data platform.

Deliverables & Due Dates

Deliverables		October 2016 – July *2019*		
1	Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	10/31/16		
2	Configuration and Publication for Providers, Programs, and Services Tool 1.0, & Full Service Partnerships Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)		05/30/19	
3	Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)			07/28/18

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

Back to Agenda

MHSOAC Evaluation Dashboard September 2018

(updated 09/06/18)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff: Pu Peng & Brandon McMillen

Active Dates: 12/28/17 - 12/31/18

Total Contract Amount: $423,923

Total Spent: ***$285,793***

Objective: To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverables & Due Dates

	Deliverables	December 2018
1	Secure Data Management Platform	12/28/17
2	Visualization Portal	12/28/17
3	Data Management Support Services	12/31/18

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

Back to Agenda

MHSOAC Evaluation Dashboard September 2018

(updated 09/06/18)

Mental Health Services
Oversight & Accountability Commission

Regents of University of California, Los Angeles

Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff: Michelle Adams

Active Dates: July 1, 2018 - July 31, 2020

Total Contract Amount: $*1,200,000*

Total Spent: *$0*

Objective: The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to 1) negative outcomes of mental illness, 2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes, 3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden), 4) capacity of the service delivery system to provide treatment and support, 5) successful delivery of mental health services, & 6) population health measures for mental health program client populations.

Deliverables & Due Dates

Deliverables		September 2019 – June 2020				
1	***Work Plan***	***9/30/19***				
2	***Outcomes Reporting Draft Report***		***12/31/19***			
3	***Outcomes Reporting Final Report***			***6/01/20***		
4	***Outcomes Reporting Data Library & Data Management Plan***				***6/01/20***	
5	***Data Fact Sheets and Data Briefs***					***6/01/20***

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

Back to Agenda

MHSOAC Evaluation Dashboard September 2018

(updated 09/06/18)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff: Rachel Heffley & Pu Peng

Active Dates: 07/01/18 - 09/30/19

Total Contract Amount: $ 234,279

Total Spent: $0

Objective: The intention of this pilot program is to work with a three county sample (Amador, Los Angeles, & Orange) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics.

Deliverables & Due Dates		
Deliverables		**January 2019- August 2019**
1	***FSP Program Data Sets***	***1/25/19***
2	***FSP Formatted Data Sets***	***5/06/19***
3	***FSP Draft Report***	***6/28/19***
4	***FSP Final Report***	***8/30/19***

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

Back to Agenda

Mental Health Services Oversight & Accountability Commission

INNOVATION DASHBOARD - SEPTEMBER 2018 (Current)

	NUMBER OF PLANS	COUNTIES	FUNDS REQUESTED
CALENDARED*	19	13	$96,126,057
DRAFT PROPOSALS RECEIVED	11	7	$35,718,570
TOTAL	**30**	**20**	**$131,844,627**

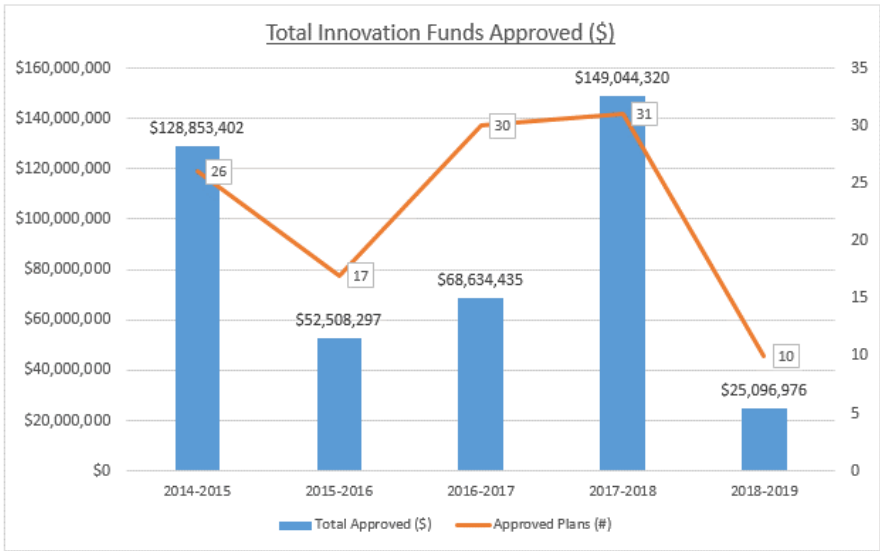
AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
50 days†

Draft → Final → Calendared

*** September:** Kings (1), City of Berkeley (1), Tehama (1), Tri-City (1), Riverside (1), Monterey (1), San Mateo (1), Marin (1), San Francisco (1), Santa Barbara (1), Santa Barbara (1 extensions), Inyo (1), Los Angeles (2)
* **October:** Alameda (4), San Francisco (1)

† This excludes four (4) plans involving existing project extensions and Tech Suite additions

Previous FY Trends:



Number of Counties that have presented an INN Plan to the Commission since 2013:	
54	**92%**

Number of Counties that have NOT presented an INN Plan to the Commission since 2013:	
5	**8%**

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19 (to date)
APPROVED INN Funds:	$127,742,348	$46,920,919	$66,625,827	$143,871,714	$25,096,976
APPROVED Ext. Funds:	$1,111,054	$5,587,378	$2,008,608	$5,172,606	$531,120
Plans Received:	N/A	N/A	33	34	10
Plans APPROVED:	26	17	30 (91%)	31 (91%)	10 (100%)
Participating Counties:	16	15	18 (31%)	19 (32%)	7 (12%)
Participating Counties APPROVED:	N/A	N/A	17 (94%)	16 (84%)	7 (100%)

Back to Agenda

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	Santa Barbara	Resiliency Interventions for Sexual Abuse (RISE)	$2,600,000.00	2 Years	N/A	4/12/2018	SEPTEMBER
CALENDARED	Kings	The Multiple-Organization Shared Telepsychiatry (MOST) Project	$1,633,631.00	3 Years	6/13/2018	8/27/2018	SEPTEMBER
CALENDARED	Tehama	TECH SUITE	$118,088.00	2 Years	3/28/2018	6/19/2018	SEPTEMBER
CALENDARED	Tri-City	TECH SUITE	$1,674,755.13	4 Years	4/5/2018	7/19/2018	SEPTEMBER
CALENDARED	City of Berkeley	TECH SUITE	$462,916.00	3 Years	4/24/2018	8/3/2018	SEPTEMBER
CALENDARED	Riverside	TECH SUITE	$25,000,000.00	4 Years	4/9/2018	8/27/2018	SEPTEMBER
CALENDARED	Monterey	TECH SUITE	$2,526,000.00	3 Years	5/2/2018	7/13/2018	SEPTEMBER
CALENDARED	San Mateo	TECH SUITE	$3,872,167.00	2 Years	5/9/2018	8/16/2018	SEPTEMBER
CALENDARED	Marin	TECH SUITE	$638,000.00	21 Months	4/30/2018	8/17/2018	SEPTEMBER
CALENDARED	San Francisco	TECH SUITE	$2,273,000.00	5 Years	5/17/2018	8/8/2018	SEPTEMBER
CALENDARED	Santa Barbara	TECH SUITE	$4,912,852.00	5 Years	6/6/2018	8/17/2018	SEPTEMBER
CALENDARED	Inyo	TECH SUITE	$448,757.00	3 Years	7/2/2018	8/17/2018	SEPTEMBER
CALENDARED	Los Angeles	Therapeutic Transportation	$18,342,400.00	3 Years	7/16/2018	9/6/2018	SEPTEMBER

Back to Agenda

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	Los Angeles	Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community	$16,282,502.00	5 Years	6/22/2018	7/16/2018	SEPTEMBER
CALENDARED	Alameda	Cannabis Policy and Education Project	$1,380,875.00	3 Years 3 months	3/12/2018	8/6/2018	OCTOBER
CALENDARED	Alameda	Community Assessment and Transport Team (CAT)	$9,878,082.00	5 Years	3/22/2018	8/6/2018	OCTOBER
CALENDARED	Alameda	Transitional Age Youth Emotional Emancipation Circles	$501,808.00	2 Years 6 Months	3/22/2018	8/6/2018	OCTOBER
CALENDARED	Alameda	Introducing Neuroplasticity to Mental Health Services for Children	$2,054,534.00	4 Years	4/18/2018	8/6/2018	OCTOBER
CALENDARED	San Francisco	Wellness in the Streets	$1,750,000.00	5 Years	5/17/2018		OCTOBER

CALENDARED: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Tulare	Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication	$1,382,734	5 Years	12/15/2017		
DRAFT	Tulare	Connectedness2Community	$765,175	5 Years	12/15/2017		
DRAFT	Calaveras	Enhancing the Journey to Wellness/Peer Navigator Program	$710,609	5 Years	6/6/2018	Expected Early August	
DRAFT	Tuolomne	Building a Compassionate Response to Trauma in a Rural Community	$1,248,073	5 Years	3/26/2018	6/19/2018	
DRAFT	Los Angeles	Removing Barriers to Mental Health Optimization, through a Suite of On-Demand Services	$6,247,874	3 Years	7/23/2018		

Back to Agenda

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Los Angeles	Utilizing Transportation Network Companies to Optimize Client Outcomes	$3,765,780	3 Years	7/23/2018		
DRAFT	Los Angeles	Enhancing Workforce Training through Mixed Reality Approaches	$11,464,196.00	5 Years	6/22/2018	7/16/2018	
DRAFT	Los Angeles	Trauma Informed Resilience Leadership Training, A Solution to Community Trauma	$7,126,144	4 Years	7/23/2018		
DRAFT	City of Berkeley	Trauma-Informed Care for Educators	$340,000		6/29/2018		
DRAFT	San Benito	Behavioral Health-Diversion and Re-Entry Court	$2,264,566.00	5 Years	8/28/2018		
DRAFT	Colusa	Social Determinants of Rural Mental Health Projects	$403,419.00	3 Years	8/30/2018		

DRAFT: A County plan submitted to the OAC that contains some of the regulatory requirements, including but not limited to a full budget

Back to Agenda

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
    a. County presentations should be no more than 10-15 minutes in length
    b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
    c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **PowerPoint Presentation**
    a. Recommend bulleted slides to allow County to discuss and highlight project and dialogue
    b. Recommend 5 slides and include the following five (5) items:
        i. Presenting Problem / Need
        ii. Proposed Innovation Project to address need
        iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
        iv. Innovation Budget
        v. If successful, how will Innovation Project be sustained?

3. **County Brief (optional)**
    a. Recommend 2-4 pages total and should include the following three (3) items:
        i. Summary of Innovation Plan / Project
        ii. Budget
        iii. Address any areas indicated in the Staff summary

4. **Presenters and Biographies**
    a. We request no more than a few (2-4) presenters per Innovation Project
        i. If the county wishes to bring more presenters, support may be provided during the public comment period
    b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
        i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

Back to Agenda

Calendar of Commission Meeting Draft Agenda Items

Proposed 9/18/18

All agenda items and meeting locations are subject to change

October 25: Alameda, Marina Inn

- **Suicide Prevention Panels**
  Subject matter experts and stakeholders will present information regarding suicide prevention in support of the Commission's efforts toward the creation of a statewide suicide prevention strategy.

- **Innovation Project: Alameda County**
  1. Cannabis Policy and Education Support
  2. Community Assessment and Transport Team
  3. Emotional Emancipation Circles for Young Adults
  4. Neuroplasticity for Children

- **Innovation Project: San Francisco County**
  1. Wellness in the Streets

- **Immigrant/Refugee RFP Outline**
  The Commission will consider approval of an outline for an Immigrant and Refugee RFP.

- **Chair/Vice Chair Elections**
  The Commission will elect the Chair and Vice Chair for 2019.

November 14-15: (2-day meeting) Riverside, Mission Inn

November 14th:

- **Innovation Project: City of Berkeley (Extension)**
  1. Trauma Informed Care Training

- **Innovation Project: Calaveras County**
  1. Enhancing the Journey to Wellness Peer Specialist Program

- **Programs, Providers, and Services Tool**
  The Commission will receive a progress report and demonstration of the Programs, Providers, and Services Transparency Tool.

- **Use of County Innovation Funds**
  The Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.

November 15th:

- **Strategic Planning Session**
  The Commission will continue the facilitated strategic planning discussion about the role of the Commission, and the goals and objectives of the Strategic Plan which will be developed through the strategic planning process led by Susan Brutschy, President of Applied Survey Research.

Back to Agenda

Calendar of Commission Meeting Draft Agenda Items

December: No Meeting

January 24: Sacramento, MHSOAC

- **Triage Program Update**
  The commission will hear an update on the status of the Triage grants and will receive information about how Triage counties adjusted to the reduction of funding.

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.

- **Overview of Governor's Budget**
  The Department of Finance will provide an overview of the Governor's proposed budget for fiscal year 2019-20 and its impact on the community mental health system.

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

- **Awarding of the Immigrant/Refugee Stakeholder contract**
  The Commission will consider awarding a stakeholder contract in the amount of $2,010,000 to the highest scoring applicant for the Immigrant and Refugee Stakeholder contract.

February 28: Sacramento , MHSOAC

- **Presentation of Stakeholder State of the Community reports**
  The Commission will hear a presentation by each of the seven contracted stakeholders on their State of the Community reports; a required contract deliverable outlining the work done on behalf of the specific populations.

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

March 28: Location TBD

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.

- **Schools and Mental Health Final Report**
  The Commission will consider adopting the Schools and Mental Health final report.

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

Agenda Item 4, Enclosure 6: DHCS Status Chart of County RERs Received
September 27, 2018 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated September 6th, 2018.

This Status Report covers the FY 2012-13 through FY 2016-17 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting year FY 2016-17 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

On July 1, 2018 DHCS published a report detailing MHSA funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage:
http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

Agenda Item 4, Enclosure 6

DHCS MHSA Annual Revenue and Expenditure Status Update

	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	1/4/2015	1/6/2015	1/10/2017	1/5/2017	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018
Alpine	9/12/2016	9/13/2016	9/12/2016	9/13/2016	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018
Amador	10/30/2015	9/9/2016	9/8/2016	3/27/2017	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018
Berkeley City	7/6/2015	7/17/2015	4/18/2016	5/2/2016	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018
Butte	4/10/2015	4/13/2015	3/7/2016	3/7/2016	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018
Calaveras	12/1/2015	12/1/2015	12/18/2015	1/19/2016	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018
Colusa	3/27/2015	8/4/2015	11/16/2015	11/16/2015	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018
Contra Costa	4/13/2015	4/14/2015	3/8/2016	3/14/2016	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018
Del Norte	4/1/2015	4/15/2015	11/2/2015	1/4/2016	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018
El Dorado	4/1/2015	4/7/2015	12/15/2015	8/29/2016	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018
Fresno	3/25/2015	4/21/2015	10/30/2015	11/12/2015	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018
Glenn	4/30/2015	5/1/2015	10/30/2015	11/4/2015	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018
Humboldt	2/10/2015	4/8/2015	6/3/2016	6/6/2016	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018
Imperial	4/1/2015	4/8/2015	10/28/2015	11/3/2015	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018
Inyo	5/29/2015	6/29/2015	11/19/2015	12/5/2015	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018
Kern	3/27/2015	4/2/2015	11/12/2015	11/12/2015	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018
Kings	4/17/2015	6/5/2015	4/7/2016	7/26/2016	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018
Lake	1/31/2018	1/31/2018	2/12/2018	2/12/2018	7/25/2018	7/26/2018	7/25/2018	7/26/2018			
Lassen	3/30/2015	7/27/2015	11/1/2015	12/16/2015	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018
Los Angeles	5/6/2015	7/29/2015	10/17/2016	10/19/2016	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018
Madera	4/1/2015	11/8/2016	11/13/2016	12/7/2016	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018
Marin	3/11/2015	3/12/2015	9/6/2016	9/6/2016	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018
Mariposa	6/26/2015	6/29/2015	9/23/2016	9/23/2016	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018
Mendocino	5/1/2015	5/1/2015	10/28/2015	10/28/2015	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018
Merced	5/9/2015	10/15/2015	10/20/2015	10/21/2015	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018
Modoc	3/11/2015	3/12/2015	10/27/2015	11/10/2015	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018
Mono	5/1/2015	6/2/2015	3/30/2016	4/4/2016	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018
Monterey	4/27/2015	5/6/2015	10/20/2017	10/23/2017	3/29/2018	4/23/2018					
Napa	6/17/2015	8/25/2017	8/18/2017	8/25/2017	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018
Nevada	4/1/2015	4/2/2015	11/3/2015	11/23/2015	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018
Orange	4/1/2015	4/7/2015	10/29/2015	10/5/2016	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018
Placer	4/1/2015	12/16/2017	10/4/2016	10/5/2016	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018
Plumas	11/3/2015	11/3/2015	4/10/2017	4/10/2017	6/8/2017	6/23/2017	3/27/2018	3/28/2018			
Riverside	4/1/2015	4/6/2015	10/30/2015	11/2/2015	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018
Sacramento	12/11/2015	12/11/2015	9/21/2016	9/21/2016	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018
San Benito	4/8/2015	4/14/2015	4/18/2016	4/19/2016	10/24/2016	3/8/2016	9/8/2017	9/12/2017			
San Bernardino	4/1/2015	4/14/2015	11/17/2015	11/17/2015	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018
San Diego	4/8/2015	4/8/2015	12/2/2015	9/28/2016	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018
San Francisco	4/17/2015	4/21/2014	10/30/2015	11/2/2015	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018
San Joaquin	4/2/2015	4/7/2015	11/10/2016	11/10/2016	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018
San Luis Obispo	4/3/2015	4/6/2015	11/6/2015	9/29/2016	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018
San Mateo	3/15/2016	3/17/2016	9/28/2016	10/3/2016	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018
Santa Barbara	4/2/2015	5/8/2015	5/24/2017	5/24/2017	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018
Santa Clara	4/18/2017	4/20/2017	4/18/2017	4/20/2017	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018
Santa Cruz	4/2/2015	4/17/2014	3/18/2016	3/23/2016	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018
Shasta	10/29/2015	11/2/2015	10/29/2015	9/30/2014	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018
Sierra	10/9/2015	11/2/2015	10/17/2016	10/18/2016	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018
Siskiyou	10/30/2015	3/24/2017	6/30/2017	7/10/2017	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		
Solano	4/1/2015	4/6/2015	10/29/2015	11/3/2015	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018
Sonoma	12/18/2015	11/20/2016	12/6/2016	12/6/2016	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018
Stanislaus	3/19/2015	4/3/2015	10/27/2015	10/28/2015	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018
Sutter-Yuba	11/19/2015	12/22/2015	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018
Tehama	5/29/2015	6/19/2015	3/31/2016	4/4/2016	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018
Tri-City	4/3/2015	4/16/2015	10/30/2015	2/3/2016	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018
Trinity	10/9/2015	10/14/2015	3/23/2016	3/23/2016	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018
Tulare	3/26/2015	6/9/2015	12/3/2015	12/3/2015	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018
Tuolumne	4/1/2015	4/7/2015	10/26/2015	11/2/2015	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018
Ventura	6/19/2015	6/30/2015	10/29/2015	11/3/2015	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018
Yolo	4/2/2015	4/7/2015	6/16/2017	6/21/2017	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018
Total	59	59	59	59	59	59	58	58	55		54

Current Through: 09/06/2018

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

2018 Legislative Report to the Commission
September 17, 2018

SPONSORED LEGISLATION

Senate Bill 1019 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Current law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the Investment in Mental Health Wellness Act of 2013 be made available to selected counties or counties acting jointly, except as otherwise provided, and used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under. This bill would require the commission, when making these funds available, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission.

Status/Location: 9/5/2018 Enrolled and presented to the Governor.

Senate Bill 1113 (Monning)

Title: Mental health in the workplace: voluntary standards.

Summary: Would authorize the Mental Health Services Oversight and Accountability Commission to establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, determined by the commission, to support the mental health and wellness of employees.

Status/Location: 9/11/18 Signed by the Governor.

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

SUPPORTED LEGISLATION

Senate Bill 192 (Beall) – Support in concept.

Title: Mental Health Services Fund.

Summary: The MHSA authorizes a county to maintain a prudent reserve to ensure that services do not have to be significantly reduced in years in which revenues are below the average of previous years. The MHSA, except as specified, requires any funds allocated to a county that have not been spent for their authorized purpose within 3 years to revert to the state to be deposited into the fund and available for other counties in future years. This bill would clarify that the value of a prudent reserve for a Local Mental Health Services Fund shall not exceed 33% of the average Community Services and Support revenue received, in the preceding 5 years. The bill would require the county to reassess the maximum amount of the prudent reserve every 5 years and to certify the reassessment as part of its 3-year program and expenditure plan required by the MHSA.

Status/Location: 9/10/18 Signed by the Governor.

Senate Bill 215 (Beall)

Title: Diversion: mental disorders.

Summary: Would authorize a court, with the consent of the defendant and a waiver of the defendant's speedy trial right, to postpone prosecution of a misdemeanor or a felony punishable in a county jail, and place the defendant in a pretrial diversion program for up to 2 years if the court is satisfied the defendant suffers from a mental disorder, that the defendant's mental disorder played a significant role in the commission of the charged offense, and that the defendant would benefit from mental health treatment. For specified offenses, the bill would condition granting diversion on the consent of the prosecution.

Status/Location: 9/6/18 Enrolled and presented to the Governor.

Senate Bill 688 (Moorlach)

Title: Mental Health Services Act: revenue and expenditure reports.

Summary: Current law requires the State Department of Health Care Services, in consultation with the commission and the County Behavioral Health Directors Association of California, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, which gathers specified information on mental health spending as a result of the MHSA, including the expenditures of funds distributed to each county. Current law requires counties to electronically submit the report to the department and the commission. This bill would require counties to prepare the reports in accordance with generally accepted accounting principles, as specified.

Status/Location: 9/14/18 Signed by the Governor.

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

Senate Bill 906 (Beall)

Title: Medi-Cal: mental health services: peer, parent, transition-age, and family support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2019, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists.

Status/Location: 9/12/18 Enrolled and presented to the Governor.

Senate Bill 1004 (Wiener)

Title: Mental Health Services Act: prevention and early intervention.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, to establish specified priorities for the use of prevention and early intervention funds and to develop a statewide strategy for monitoring implementation of prevention and early intervention services, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The bill would require the commission to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

Status/Location: 9/12/2018 Enrolled and presented to the Governor.

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

LEGISLATION UNDER REVIEW

Senate Bill 1101 (Pan)

Title: Mental health.

Summary: Would require the commission, on or before January 1, 2020, to establish statewide objectives for the prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change, and metrics by which progress toward each of those objectives may be measured.

Status/Location: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).

Assembly Bill 1215 (Weber)

Title: Mental Health Services Act: innovative programs: research

Summary: Would, if research is chosen for an innovative project, require a county mental health program to consider, but not require, to implement, research of the brain.

Status/Location: 8/28/18 Signed by the Governor.

Assembly Bill 2287 (Kiley)

Title: Mental Health Services Act.

Summary: Would require the Mental Health Services Oversight and Accountability Commission to develop a local government transparency and accountability strategy for local mental health programs that includes fiscal, program and outcome components, as specified. The bill would also require the commission to develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health.

Status/Location: 5/25/18 Failed Deadline pursuant to Rule 61(b)(8).

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

Assembly Bill 2843 (Gloria)

Title: Mental Health Services Fund.

Summary: Would state the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within 2 years of adopting an expenditure plan for those funds. It would further state the intent of the Legislature that any funds not expended by a county within those 2 years would revert to the Mental Health Services Fund to be redistributed to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA.

Status/Location: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).

Senate Bill 1206 (de León)

Title: Mental Health Services Fund.

Summary: Would enact the No Place Like Home Act of 2018 and provide for submission of that act to the voters at the November 6, 2018, statewide general election. The bill would include any appropriation or transfer to the No Place Like Home Fund from the General Fund or other funds as moneys required to be paid into the No Place Like Home Fund. The bill would specify that the service contracts between the authority and the department may be single-year or multiyear contracts and provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount.

Status/Location: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).

Back to Agenda

AGENDA ITEM 5

Action

September 27, 2018 Commission Meeting

Santa Barbara County Innovation Plan Extension

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Santa Barbara County's request to extend the funding and project duration for its Innovative project: Resiliency Interventions for Sexual Exploitation (RISE) – previously approved as Girls Resiliency Restoration and Reintegration aLliance (GRRRL), for a total amount of $2,600,000 and a project duration of (2) two years.

- **Resiliency Interventions for Sexual Exploitation (RISE) - $2,600,000- EXTENSION**

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

The County is requesting an extension of time and funding for this Innovation. Initially approved in 2015 as a three-year project, Resiliency Interventions for Sexual Exploitation (RISE) was designed to increase the quality of services, including better outcomes, for girls who are victims of (or at risk for) sexual exploitation through sexual trafficking. The program intended to utilize an interagency and community collaboration with numerous agencies who may come in contact with these girls, including but not limited to law enforcement, courts, social services, alcohol and drug services, mental health providers so that the girls are provided access to treatments and supports with a focus on trauma sensitive interventions.

Over the course of the first three years of this Innovation, the County discovered that building the infrastructure to provide the require services was labor and time intensive for a number of reasons-staffing, locating a secure and confidential service site, and not the least of which, establishing trusting relationship with

victims of human trafficking. This extension will allow the County to establish the fledgling interventions as a promising practice, continue to refine the screening and assessment tool, develop an interventions "toolkit" for statewide use and meet the community demand for this critical intervention.

Presenter(s):

- Lindsay Walter, J.D., Deputy Director of Operations and Administration Santa Barbara County
- Lisa Conn Akoni, MA., Marriage & Family Therapist
- Carissa Phelps, J.D.

Enclosures (3): (1) Biographies for Santa Barbara County Presenters (2) Staff Analysis, Resiliency Interventions for Sexual Exploitation (RISE); (3) County Project Brief, Resiliency Interventions for Sexual Exploitation (RISE)

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

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

http://mhsoac.ca.gov/document/2018-08/santa-barbara-county-resiliency-interventions-sexual-exploitation-rise-august-23

Proposed Motion: The MHSOAC approves Santa Barbara County's request for $2,600,000 additional funding and extension of time for its Resiliency Interventions for Sexual Exploitation (RISE) previously approved by the Commission on May 28, 2015 as follows:

Name:	Resiliency Interventions for Sexual Exploitation (RISE)
Additional Amount:	$2,600,000 for a total INN project budget of $5,107,749
Additional Project Length:	Two (2) years for a total project duration of (5) five years.

Back to Agenda

Biographies for Santa Barbara County Presenters

Lindsay Walter, J.D. – Deputy Director of Operations and Administration

Lindsay Walter, JD, has served as Deputy Director for Administration and Operations since April 2016 for Santa Barbara County Department of Behavioral Wellness. Ms. Walter earned a BA degree in Economics from the University of California Los Angeles, and became an attorney after receiving a Juris Doctorate degree from Santa Barbara College of Law. She joined the Department of Behavioral Wellness in 2006 as an Accountant, was promoted to the role of an Accountant Supervisor, Fiscal Business Manager and, Interim Chief Financial Officer. In her spare time, she enjoys volunteering as a Board Member for the Santa Barbara Rape Crisis Center and beach walks with family.

Lisa Conn Akoni, MA., Marriage & Family Therapist:

Lisa has worked in the field of family, child and adolescent behavioral health for over 20 years; earning her Bachelors at University of California Santa Cruz and her Masters of Clinical Psychology degree from Antioch University Santa Barbara. Her academic training and expertise is in Clinical Psychology with specializations in juvenile justice, personality disorders, DBT, gender specific care, crisis intervention, trauma focused treatment, childhood/adolescent trauma and sexual exploitation. Her primary passion is developing innovative supports for girls and young women to promote restoration and reintegration through *empowerment and resiliency* building. Lisa is the Supervisor and program developer for the RISE Project (*Resiliency Interventions for Sexual Exploitation*) with Santa Barbara County Department of Behavioral Wellness. Prior to her current project and position, she was the Supervisor for SB County Behavioral Wellness Juvenile Justice Mental Health Services, overseeing behavioral supports and program development for juvenile justice involved youth, particularly focusing on trauma exposed females.

She is actively involved in several female/gender-specific projects, workgroups & community collectives in efforts to create innovative, trauma-informed, gender-specific and best/promising practice interventions for trauma exposed and sexually exploited LGBT/GNC youth, girls & young women. She also provides numerous local, state and national multi-disciplinary trainings, presentations and media interviews focusing on DBT, Trauma Informed Care, Childhood Trauma, Juvenile Justice Involved Youth, Female-Specific Treatment, Sexual Exploitation and CSEC (*Commercial Sexual Exploitation of Children*). (California Health Report; Santa Maria Sun Times Interview; Forensic Mental Health Association California). She recently presented at Shared Hope's JuST Conference for *Juvenile Sex Trafficking* in Washington DC.

Carissa Phelps

Carissa Phelps is a California attorney with a J.D. from UCLA School of Law. She is founder and CEO of Runaway Girl, Inc. (RG), a first-of-its-kind social purpose corporation, which helps communities respond to human trafficking and inspires individuals who have survived human trafficking to embrace freedom and pursue their dreams. Carissa has been a leader in the anti-human trafficking movement since the 2008 premiere of CARISSA, an award-winning documentary about her life. The film, along with her 2012 memoir *Runaway Girl: Escaping Life*

on the Streets One Helping Hand at a Time (Viking), are used across the country as teaching tools on child welfare, human trafficking, and criminal justice.

Her combined education and experience as a social entrepreneur make Carissa a sought-after speaker and resource. She has helped to bring national and local attention to human trafficking and has been part of significant changes in related legislation, policies, and procedures. A strong advocate for victims' rights and the provision of impactful and life changing services for survivors, Carissa directly supports and mentors survivor entrepreneurs. She also works with them to increase access to vital services for victims of human trafficking in every community.

In addition to her law degree, she holds a Masters of Business Administration from UCLA Anderson and a Bachelor of Arts in mathematics, summa cum laude, from Fresno State University. She has earned several honors and awards, including UCLA Anderson's Top 100 Inspirational Alumni (2010) and Fresno State's Top Dog Outstanding Alumni Award (2013).

Back to Agenda

STAFF ANALYSIS - SANTA BARBARA COUNTY

Innovative (INN) Project Name:	**Resiliency Interventions for Sexual Exploitation (RISE)**
Extension Funding Requested for Project:	**$2,600,000**
Duration of Extension:	**2 years**

Review History:

MHSOAC Original Approval Date: 05/28/2015

- Original Program Dates: 07/01/2015 through 6/30/2018 (3 years)
- Original Budget: $2,507,749
- New Budget: $2,600,000
- New Total Budget with Evaluation Costs: $5,107,749

Approved by the County Board of Supervisors:	June 1, 2018
County Submitted Innovation (INN) Project:	April 12, 2018
MHSOAC Consideration of INN Project:	August 23, 2018

Project Introduction:

The County is requesting an extension of time and funding for this Innovation. Initially approved in 2015 as a three-year project, Resiliency Interventions for Sexual Exploitation (RISE) was designed to increase the quality of services, including better outcomes, for girls who are victims of (or at risk for) sexual exploitation through sexual trafficking. The program intended to utilize an interagency and community collaboration with numerous agencies who may come in contact with these girls, including but not limited to law enforcement, courts, social services, alcohol and drug services, mental health providers so that the girls are provided access to treatments and supports with a focus on trauma sensitive interventions.

Over the course of the first three years of this Innovation, the County discovered that building the infrastructure to provide the required services was labor and time intensive for a number of reasons: staffing, locating a secure and confidential service site, and not the least of which, establishing trusting relationship with victims of human trafficking. This extension will allow the County to establish the fledgling interventions as a promising

practice, continue to refine the screening and assessment tool, develop an interventions "toolkit" for statewide use and meet the community demand for this critical intervention.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- *What is the unmet need that the county is trying to address?*
- *Does the proposed project address the need?*
- *Are there clear learning objectives that link to the need?*
- *Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?*

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project 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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

The County indicates that some of the reasons it is requesting an extension of time and money for this project are:

- Additional time is necessary because of startup delays related to hiring and training staff with specific expertise in serving the sexually trafficked population.
- Additional time is necessary since a secure site for services and other required operational barriers (i.e. transportation, developing and implementing training modules, etc.) required specific service and security agreements.
- Additional funding is necessary to allow the County to develop a toolkit (one of the overarching goals for this Innovation)
- Additional funding is necessary to allow the multi-agency team to use and share the screening and assessment tool that was developed in the first three years of the plan
- Additional funding is necessary to add new outreach groups (migrant, juvenile and child welfare systems individuals and gender identity populations) since those had been seen as groups not being addressed in the current Innovation
- Additional funding is necessary to allow for additional training (public awareness regarding signs and risk of mental illness due to sex trafficking) since only 1600 of the originally intended 2600 have been trained
- Additional funding is necessary to allow for an increase in the survivor mentorship aspect of this program

The Response

Perhaps the greatest learning experience the County reports and one that adds to the complexity of completing this Innovation as originally proposed is the degree to which it had underestimated the population; numerically, experientially and philosophically. The County reports that the sexually trafficked population (regardless of race or gender) is generally mistrustful, afraid of repercussions from the group or persons trafficking them, dependent on illegal substances or submits to trafficking to obtain illegal substances, extremely transient and possibly re-traumatized by stigma associated with their lifestyle. Additionally, many trafficked individuals are runaways and have increased distrust and transient life styles. Further complicating this is that any mental health issues that made the victim susceptible or vulnerable to this type of trafficking are likely to remain undiagnosed and untreated. Clinicians have limited access to those individuals especially if they are jailed. The County has learned that their best assessment and screening tool cannot be utilized until it has established a significant relationship with the victim of trafficking.

In addition to the new screening and assessment tool, the County intends to use this extension to develop a more robust toolkit, which will include prior best behavioral health practices, data and information from their new and more informed approach as well as continuing with the multidisciplinary team approach.

Research indicates that a multi-pronged approach to providing services to victims of trafficking is essentially necessary because so many of life activities and services (i.e. housing, law enforcement, education, employment, etc.) are required to restore a victim to some kind of emotional and physical solvency. The County reports that it has developed 8 individual training/awareness programs for victims as well as collaborators, a phased approach to recovery (stabilization, coping, maintenance and leadership, and has served 101 sexually trafficked persons (100 females and one male).

The Community Program Planning (CPP) Process

A full and complete initial CPP was conducted in 2014/15. When the County realized it was going to require additional time, they went back to stakeholders and collaborators and ultimately posted the extension request. The 30 day comment period was June 5, 2018 through July 3, 2018. Approval from the Board of Supervisors occurred July 17, 2018. The feedback was all positive and the County has submitted letters of support as part of this extension request, included, but not limited to: Department of Social Services, Child Welfare Services, Medical Directors of Juvenile Detention facilities and sexual assaul65t response team, parent of a RISE participant, North County Rape Crisis and Child Protection Center.

Learning Objectives and Evaluation

With this extension, the Santa Barbara County states that their target population will be expanded to include individuals over the age of 18 with significant alcohol and other drug issues, domestic violence, developmental and/or cognitive and legal issues. This

expansion will yield a larger population and it is estimated that 160 individuals will be served annually. The learning objectives of the project remain the same as originally approved, and include:

1. Will a shared universal and measurable trauma risk screening tool be effective and result in comprehensive understanding of this population and increase trauma sensitive treatment of victims?
2. Will offering services in a trauma sensitive recovery based approach increase rapport and participation from the victims?
3. Will community education/awareness efforts increase engagement of bystanders or witnesses who may be able to aid or assist with prevention of sexual abuse?
4. Will increasing community and policy maker awareness increase funding sources to develop longer term housing and emergency shelters?

During the first phase of the project, much of the evaluation work revolved around piloting tools to screen and respond to children in the community, determine the strengths, risks, and needs of RISE participants, and determine how to track RISE project participation. Challenges and lessons learned during this phase relative to each learning objective have informed changes that will be implemented in the evaluation during the extension period (**see pgs. 14-25**).

Santa Barbara County will determine specific outcome measures and methods for collecting data in months three though five of the extension period to determine the impact of the shared screening and assessment tool. Currently, several tools and sources are being used for baseline data, and include: Adverse Childhood Experience (ACE), Social Emotional Health Survey (SEHS), Child and Adolescent Needs and Strengths (CANS), Massachusetts Youth Screening Instrument (MAYSI), arrest records, length and frequency of incarceration, placement stability reports, and consumer surveys. Possible outcomes include:

1. Improved CSEC identification and early identification
2. Increase in number of timely therapeutic interventions
3. Improved CSEC multidisciplinary team participation
4. Stronger collaborations and communications across agencies

To complete the evaluation of the project, Santa Barbara County will continue to work with the University of California at Santa Barbara, who will be responsible for completing the final evaluation report. The County has proposed developing and distributing a statewide toolkit that incorporates what was learned through the RISE project. **In recognition of lessons learned during the first phase of this project, the Commission may want to encourage Santa Barbara County to reach out to other counties with similar needs in order foster cross-county learning as well as possible statewide implementation of a tool addressing trauma risk.**

The Budget

The budget for the two extended years ($2.6M) is reflective of the learning from the first three years. Although staffing has not changed and total salary is 59% of the total budget for all five years.

The County is encouraged to be prepared to address the costs associated with this extension since they are approximately the same and for the first three years of the proposal.

The County proposes to use 27% of the total budget for project operation costs and 14% for evaluation and administrative costs.

The County may wish to identify more exact costs for evaluation since they appear to be $121K and represent a little over 2% of the total plan costs as well as contract provider costs for years 4 and 5 at $100.00 per year.

The County has identified use of AB 114 reversion funds as follows:

$259,272 from FY 2008-09 and FY 2010-11 will be utilized in FY 2018-19 to support the RISE extension. These monies were approved by the local stakeholder process and the County Board of Supervisors on July 17, 2018.

Additional Regulatory Requirements

The proposed project (extension) appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

References

https://ovc.ncjrs.gov/humantrafficking/Public_Awareness_Folder/Fact_Sheet/HT_Building_Effective_Collab_fact_sheet-508.pdf

https://www.futureswithoutviolence.org/wp-content/uploads/Collaborating-to-Help-Trafficking-Survivors-updated-links-final.pdf

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-08/santa-barbara-county-resiliency-interventions-sexual-exploitation-rise-august-23

Back to Agenda

Santa Barbara County Brief

Request for a Two-Year Extension, the RISE Innovation Project Resiliency Interventions for Sexual Exploitation

August 9, 2018

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Summary of Innovation Project

The Santa Barbara County Department of Behavioral Wellness is requesting a two-year extension, from August 2018 – July 2020, for the RISE Innovation Project.

According to local Child Welfare data (CSE-IT Tool), an estimated three in 10 youth involved in Santa Barbara County Juvenile Probation and Child Welfare systems are at risk for trafficking, greater than the regional average. The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the Santa Barbara County RISE (Resiliency Interventions for Sexual Exploitation) Innovation Project on May 28, 2015. The RISE Project is the first multidisciplinary program in Santa Barbara County to focus on the behavioral health needs of victims of child sexual exploitation.

Santa Barbara County Behavioral Wellness has encountered a higher than expected population of exploitation victims age 18 and over, exploitation victims with significant substance abuse, domestic violence, safe housing and legal issues. Resources for adult exploitation victims (18-24) experience significant resource gaps compared to minor victims in our community. Also, migrants subjected to sex and labor trafficking are higher than expected and particularly difficult to reach due to their increased fear related to immigration issues and current climate. Effective service delivery to this population require specialized culturally-specific efforts and cross-agency collaboration.

RISE is committed to the restoration and empowerment of female and LGBT/GNC youth exposed to, or at risk of, sexual exploitation and trafficking. Through trauma-specific services, collaborative partnerships and community outreach, RISE works to restore and reintegrate survivors, eradicate sexual exploitation and reduce the stigma surrounding sexual trauma in Santa Barbara County. RISE promotes hope and resiliency for female and LGBT/gender non-conforming (GNC) youth, guiding them to be leaders in their pursuit of meaningful and enriching lives.

RISE deploys a staff of 1 FTE team supervisor, .25 FTE psychiatrist, 1 FTE psych tech, 2.0 FTE practitioner interns, 2 FTE case workers, 1 FTE rehabilitation specialist, one extra help case worker, and one extra help administrative office professional (4 bilingual/bicultural staff).

Collaborating with several other Santa Barbara County partner agencies, community-based organizations and community groups, the RISE Project delivers a survivor-centered, multi-layered approach consisting of specific, trauma-focused and biopsychosocial interventions and supports to address the hierarchy of needs and restore, reintegrate, and empower young females and LGBT/GNC youth. As of July 1, 2018, 101 girls and one LGBT male, in addition to typically 1-3 family members per client, were served by RISE.

Budget Notes

(The budget appears on page 4.)

- Duration of Proposed Extension: August 2018 – July 2020
- AB 114 Reverted Funds: AB 114 Reverted funds of $259,272 from FY 2008-09 and FY 2010-11 will be used in FY 2018-19 to support the RISE extension. These monies were approved by the local stakeholder process and the County Board of Supervisors on July 17, 2018.
- Administrative Costs: Administrative costs reflect the indirect cost rate plan approved by the County Auditor's Office, which range from 18-22% of direct costs and are the overhead for Quality Assurance, which includes quality management and program evaluation staffing costs provided by the Department of Behavioral Wellness.
- Performance Evaluation: Evaluation costs reflect expenses incurred in hiring Dr. Jill Sharkey and the University of California, Santa Barbara team. Dr. Jill Sharkey is a contractor who provides evaluation services to the Department of Behavioral Wellness RISE Project to identify baseline, process, and outcome data.
- Contract Providers: This line item refers to a physician and/or other staffing assistance that is not provided by civil service staff. If, for example, a physician is providing a short-term locum contract, the budgeted salary costs shift to that line item. We use this as a placeholder.
- Facility Costs: Facility costs include the rent payment for the confidential location, offices in all regions for staff, and the facility-related charges, such as building maintenance, provision of security, janitorial services and utilities. Several partner agencies also use our site, which allows for greater collaboration.
- Training and Peer Support: The Runaway Girl contract provides Ending the Game™ (ETG) Facilitator Training to train participants of this training to become facilitators of Ending the Game™ curriculum. In addition, Runaway Girl initiated a mentorship and job skill program for RISE peer survivors. Uffizi-Human Trafficking nonprofit educates at least 3000 community members on the prevalence of human trafficking in Santa Barbara County.
- RISE Training, Education & Awareness Initiatives: Costs related to training of staff and community have included CSEC 101 Training, Ending the Game: Coercion Resiliency Training for CSEC youth, Survivor City: Similar to CSEC 102 Training, CSEC 102 Training, Trace the Case training, First Responder ID Training, Trauma-Informed Treatment Training, and Think Trauma.

- Additional Travel Costs: RISE has extensive commuting needs to serve clients. We purchased three cars; however, we often have to use motor pool to "meet our client's where they are"—literally.

Response to Issues Raised in Staff Summary

1. The budget for the two extended years ($2.6M) is reflective of the learning from the first three years. Although staffing has not changed and total salary is 59% of the total budget. Staffing expenditures for the first three years reflect the salary and benefits as the program was implemented. Staffing costs for the initial team hiring and training of those staff was $327,012 in the first year, as the team initiated a continuum of services, it increased to $641,051 during the second year, and grew to full staffing levels in year three at $894,888. The extension reflects staffing costs of $888,400 to remain close to the year three actuals. During the initial two years, the start-up costs including transportation infrastructure, equipment, clinical office space, and community awareness training were greater than the two extension years. With a full operational model, the anticipated costs are $1.3M versus the tiered increase in costs over the initial two years of start-up. In addition, the budget reflects increasing Medi-Cal revenue to support the program expenditure. Medi-Cal revenue was $676 in the first year start-up and grew to an estimated $231,800 for the extension as service levels provided increased with staffing and the interventions qualified for reimbursement.

2. The County is encouraged to be prepared to address the costs associated with this extension since they are approximately the same and for the first three years of the proposal. The initial three year budget was built to support the implementation timeline as operations grew. The first year costs were $506,511, second year of $1,272,382, and third year of $1,368,447. The requested Innovation extension funding of $1,300,000 reflects the full operational costs of $1,531,800 a year offset by Medi-Cal revenue of $231,800 for the fourth and fifth year.

3. The County may wish to identify more exact costs for evaluation since they appear to be $121K and represent a little over 2% of the total plan costs as well as contract provider costs for years 4 and 5 at $100.00 per year. Evaluation costs provided by a contractor for $121,000 over five years reflect expenses incurred in hiring Dr. Jill Sharkey and the University of California, Santa Barbara team. Behavioral Wellness' staffing for quality assurance includes a team of epidemiologists and information specialists that coordinate all data and evaluation details with Dr. Sharkey. The costs of these County personnel are included in the Department of Behavioral Wellness administrative costs of $761,824 over the five year period. In the budget, the contract provider line item is a placeholder when locum tenens or additional contract clinical staff is hired to offset vacancies of the regular county team.

Back to Agenda

RISE PROJECT BUDGET

Component	Year 1	Year 2	Year 3	Year 4	Year 5	Total	% Budget
	FY 15-16	FY 16-17	FY 17-18	EXTENSION	EXTENSION		
Staffing							
Salaries	$197,429	$383,469	$516,730	$586,400	$586,400	$2,270,428	
Benefits	$129,583	$257,582	$378,158	$302,000	$302,000	$1,369,323	
Total	**$327,012**	**$641,051**	**$894,888**	**$888,400**	**$888,400**	**$3,639,751**	**59%**
Operations for Project							
Facility - Maintenance, Rent, Janitorial, Security, Utilities	$96,412	$188,837	$28,077	$109,000	$109,000	$531,326	
Client Expense - Food, Clothing, Shelter, Housing, Lodging	$668	$2,237	$18,444	$53,400	$53,400	$128,150	
Operating Supplies - Copier, Licenses, Office Expense, All Other	$2,549	$11,692	$26,699	$45,500	$45,500	$131,940	
Travel - In County Cars, Mileage, Meetings, and Conferences	$5,383	$121,242	$42,442	$4,900	$4,900	$178,867	
Information Technology - Software, Hardware, Phone, Maintenance	$13,695	$8,904	$14,615	$27,400	$27,400	$92,014	
Staff and Community Training & Peer Mentor Consultant	$10,146	$24,681	$76,852	$40,000	$40,000	$191,679	
Contract Providers - Physician / Staff Support	$3,384	$4,664	$25,157	$0	$0	$33,205	
County Operations Service Charges	$1,252	$95,869	$74,025	$114,800	$114,800	$400,746	
Total	**$133,488**	**$458,125**	**$306,312**	**$395,000**	**$395,000**	**$1,687,926**	**27%**
Evaluation and Adminstration							
BeWell Administrative Costs - Admin, Quality Assurance, Evaluation	$46,011	$141,886	$137,127	$218,400	$218,400	$761,824	
Evaluation - University of California at Santa Barbara / Jill Sharkey	$0	$31,320	$30,120	$30,000	$30,000	$121,440	
Total	**$46,011**	**$173,206**	**$167,247**	**$248,400**	**$248,400**	**$883,264**	**14%**
Total Proposed Expense Budget	**$506,511**	**$1,272,382**	**$1,368,447**	**$1,531,800**	**$1,531,800**	**$6,210,940**	
Less: Offseting Revenus (Medi-Cal)	**($676)**	**($41,781)**	**($176,922)**	**($231,800)**	**($231,800)**	**($682,980)**	
Total MHSA Innovations Budget	**$505,834**	**$1,230,601**	**$1,191,525**	**$1,300,000**	**$1,300,000**	**$5,527,961**	
Total Two Year MHSA Innovations Extension Request				**$1,300,000**	**$1,300,000**	**$2,600,000**	

Back to Agenda

AGENDA ITEM 6

Action

September 27, 2018 Commission Meeting

Technology Suite Collaborative Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will hear a combined presentation from the Technology Suite Collaborative leadership representing the ten (10) counties collectively referred to as Cohort Two: City of Berkeley, Inyo County, Marin County, Monterey County, Riverside County, San Francisco, San Mateo County, Santa Barbara County, Tehama County and Tri-City. The Commission will consider approval of each innovation proposal to join the existing Technology Suite Collaborative for a total amount of $42,868,480.

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.

Background:

- On October 26, 2017, the Commission approved Los Angeles and Kern County's Innovation Proposal to work collaboratively with the Joint Powers Authority, CalMHSA, and multiple counties to develop a demonstration project to increase access to mental health services to underserved groups by implementing a group of technology-based mental health solutions.
- The Technology Suite Project is comprised of five (5) components. The first three (3) are mental health application components which participating counties have the option to choose from: Peer Chat and Digital Therapeutics, Therapy Avatar and Digital Phenotyping/Wellness Monitoring. The last two (2) are universal components: community engagement/ outreach and outcome evaluation that all counties participate in.

- Mono County was approved to join the Tech Suite Collaborative on February 22, 2018. Orange County and Modoc County were approved to join the Tech Suite Collaborative on April 26, 2018.
- The Commission has received an additional ten (10) proposals to join the Tech Suite Collaborative:
- If Cohort Two is approved, the innovation investment will total $102 million from fifteen (15) counties.

Previously Approved	Commission Approval Date	Online Peer Chat and Support Groups	Virtual Therapy Using an Avatar	Digital Phenotyping/Wellness Monitoring
Los Angeles	October	X	X	X
Kern	October	X	X	X
Mono	February	X	X	X
Modoc	April	X	X	X
Orange	April	X	X	X
Proposing to Join	**Commission Date**	**Online Peer Chat and Support Groups**	**Virtual Therapy Using an Avatar**	**Digital Phenotyping/Wellness Monitoring**
City of Berkeley	September	X	X	X
Inyo	September			X
Marin	September	X	X	X
Monterey	September			
Riverside	September	X	X	X
San Francisco	September	X	X	
San Mateo	September	X	X	X
Santa Barbara	September	X		
Tehama	September	X	X	X
Tri-City	September	X	X	X

Presenters for Technology Suite Collaborative, Cohort Two:

- Karin Kalk, Tech Suite Project Manager
- Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire
- Imo Momoh, M.P.A., Director, Mental Health Services Act, San Francisco County Department of Public Health
- Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services
- Dara H. Sorkin, PhD Associate Professor Department of Medicine University of California, Irvine

Enclosures (3): (1) Biographies for Tech Suite Collaborative, Cohort Two Presenters, (2) Staff Analysis for Tech Suite Collaborative, Cohort Two, (3) Brief for Tech Suite Collaborative, Cohort Two

Back to Agenda

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

Additional Materials (10): Link to the Tech Suite Status Report is available on the MHSOAC website at the following URL:

http://mhsoac.ca.gov/file/city-berkeleyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/inyocountyinnplantech-suite08232018finalpdf

http://mhsoac.ca.gov/file/marincountyinnplantechsuite2018finalpdf

http://mhsoac.ca.gov/file/montereycountyinnplanscreening-timely-assessment2018pdf

http://mhsoac.ca.gov/document/2018-09/technology-suite-collaborative-project-plan-riverside-september-2018

http://mhsoac.ca.gov/file/san-francisco-countyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/sanmateoinnplantech-suite2018finalpdf

http://mhsoac.ca.gov/file/santabarbaracounty-innplantech-suite08232018finalpdf

http://mhsoac.ca.gov/file/tehama-countyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/tri-cityinn-plantech-suite2018finalpdf

Proposed Motions (10): The MHSOAC approves each of the following County's Innovation plans, as follows:

Name	Amount	Project Length
City of Berkeley	$462,916	3 Years
Inyo	$448,757	3 years
Marin	$1,580,000	3 Years
Monterey	$2,526,000	3 Years
Riverside	$25,000,000	3 Years
San Francisco	$2,273,000	3 Years
San Mateo	$3,872,167	3 Years
Santa Barbara	$4,912,852	5 Years
Tehama	$118,088	2 Years
Tri-City	$1,674,700	3 Years

Back to Agenda

Biographies for the Technology Suite Collaborative, Cohort Two Presenters
Multi-County Technology Suite Collaborative Innovation Project

Tech Suite Project Manager:

Karin Kalk, Project Manager: Karin is Director for Special Projects with the California Institute for Behavioral Health Solutions. Since 2001, Karin has been providing consulting services throughout California in both private and public managed care and service delivery organizations; these services have included project management, quality/process improvement, and service system design. Prior to this work in the mental health field, Karin was Vice President and General Manager for ForHealth, Inc., a venture-capital funded start-up company offering a specialized medical program for long term care residents through full and partial risk arrangements with senior health plans. Before joining ForHealth, she served as Vice President of Operations for AHI Healthcare Systems, a publicly traded managed care company serving over 200,000 members throughout the country. Karin received her Masters degree in Health Administration from Duke University, her Bachelor of Arts degree in Animal Physiology from University of California, San Diego and has additional formal training in project management and IHI's Breakthrough Series improvement methodology.

Community Representative:

Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire

County Representatives:

Imo Momoh, MPA, Director, Mental Health Services Act, San Francisco County Department of Public Health: Imo Momoh is currently the Director of the Mental Health Services Act program for the City and County of San Francisco. Imo has spent his career developing, managing, and providing leadership and innovation for programs that promote consumer empowerment, cultural humility, social justice, health equity and multicultural education. Imo once led a Bay Area Ethnic Services Managers Committee, a coalition of nine counties, charged with advocating and developing strategies towards the reduction of health disparities in the Bay Area region. With passion, Imo continues to serve local communities in an effort to increase mental health awareness, reduce stigma and increase access to care for unserved, underserved and inappropriately served communities.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services: Sharon Ishikawa is the MHSA Coordinator for Orange County. She was previously a researcher for Orange County's Community Services and Supports (CSS) programs, and earned a Doctorate in Clinical Psychology from the University of California, Los Angeles. Prior to coming to the County, she was a Project Scientist at UC Irvine and oversaw the daily operations of a clinical research project evaluating the effectiveness of Cognitive Behavior Therapy delivered over smartphones.

Evaluation Contractor, University of California, Irvine:

Dara H. Sorkin, PhD Associate Professor Department of Medicine University of California, Irvine: Dara Sorkin, PhD, is an Associate Professor in the Department of Medicine, the Director of Community Engagement for the Institute of Clinical and Translational Sciences, and the Associate Director of the Institute of Technology and Quality Care, of the University of California, Irvine. She received her Ph.D. from U.C. Irvine, in Lifespan Development Psychology. As a health services researcher, trained in sociology and psychology, she has extensive expertise in Program Evaluation (Needs Assessment, Process and Outcome); Mental Health/Trauma-Informed Care; Behavioral Health and Health Behavior Change; Development and testing of decision aids and preference elicitation; Chronic disease management; Clinical care and outcomes; Quality improvement and evaluation; Working with underserved and/or multi-ethnic/racial and multi-language populations; and Multi-method approaches to research design. Dr. Sorkin has been the PI on several NIH grants, including two R01s, authored over 50 peer-reviewed manuscripts, currently serves as a standing study section reviewer for NIH Community Level Health Promotion study section, and served as a standing study section grant reviewer for the Patient Centered Outcomes Research Institute (PCORI) Addressing Disparities Initiative (2013 to 2017).

Back to Agenda

STAFF ANALYSIS— MULTI-COUNTY COLLABORATIVE

Innovation (INN) Project Name: The Technology Suite Collaborative

Review History

On October 26, 2017, the Commission approved Los Angeles and Kern County's Innovation Proposal to work collaboratively with the Joint Powers Authority, California Mental Health Services Authority (CalMHSA), and multiple counties to develop a demonstration project called the Technology Suite Collaborative (the Collaborative) to increase access to mental health services to underserved groups by implementing a group of technology-based mental health solutions. Mono County was approved to join the Collaborative on February 22, 2018, followed by Orange County and Modoc County on April 26, 2018. To date, a total of five (5) counties were approved to join the project with a total innovation investment of a little over $59 million:

COUNTY	Total INN Funding Requested	Project Approved	Duration of INN Project
Los Angeles	$33,000,000	10/26/2017	3 Years
Kern	$2,000,000	10/26/2017	3 Years
Mono	$85,000	2/22/2018	17 Months
Orange	$24,000,000	4/26/2018	4 Years
Modoc	$270,000	4/26/2018	3 Years
Total	**$59,355,000**		

Since the initial approval in October 2017, CalMHSA and county leaders made significant progress in creating a process to centralize and simplify the contracting required to support a statewide, cross-county partnership. They also hired a contract manager and executed contracts with an evaluator, privacy and security firm and a marketing firm. Collaborative leadership state that the process improvement accomplished to date puts them in a position to quickly onboard additional counties seeking to join the Collaborative.

After approving the first five (5) counties, the Commission received an additional ten (10) proposals to join the Tech Suite Collaborative raising the total to a $102 million potential innovation investment by fifteen (15) counties:

Back to Agenda

COUNTY	Total INN Funding Requested	Duration of INN Project	County Submitted INN Project	30 day PC	Approved by BOS	Shared with MHSOAC Stakeholders
City of Berkeley	$462,916	3 Years	8/3/2018	4/24-5/23/18	6/26/2018	4/30/2018
Inyo	$448,757	3 years	8/17/2018	6/29-7/29/18	9/11/2018	7/5/2018
Marin	$1,580,000	3 Years	8/17/2018	06/27-7/27/18	9/11/2018	7/10/2018
Monterey	$2,526,000	3 Years	7/13/2018	3/23-4/23/18	6/12/2018	6/14/2018
Riverside	$25,000,000	3 Years	8/27/2018	8/16-9/15/18	September*	8/28/2018
San Francisco	$2,273,000	3 Years	8/8/2018	6/18-7/17/18	9/27/2018	8/10/2018
San Mateo	$3,872,167	3 Years	8/16/2018	5/2-6/6/18	8/7/2018	6/14/2018
Santa Barbara	$4,912,852	5 Years	8/17/2018	6/5-7/4/18	7/17/2018	6/14/2018
Tehama	$118,088	2 Years	6/19/2018	4/5-5/7/18	6/19/2018	4/6/2018
Tri-City	$1,674,700	3 Years	7/19/2018	4/4-5/3/18	6/20/2018	4/6/2018
Total	**$42,868,480**	*Riverside County seeks BOS approval after MHSOAC approval				

Collaborative Project Description

The Technology Suite Project is comprised of five (5) components. The first three (3) are mental health applications described as: (1) Peer Chat and Digital Therapeutics, (2) Therapy Avatar and (3) Digital Phenotyping/Wellness Monitoring. All participating counties choose which mental health application components they want to implement and all counties participate in the two universal components: community engagement/ outreach and outcome evaluation.

The three mental health application components are described below:

1. Peer Chat and Digital Therapeutics offered by the vendor, 7 Cups: 24/7 virtual Peer Chatting through trained and certified peers with lived experience; virtual communities of support for various populations; manualized interventions, such as mindfulness exercises, cognitive behavioral or dialectical behavior interventions; referral processes.

2. Therapy Avatar offered by the vendor, 7 Cups: Virtual evidence-based interventions delivered via an avatar; scripted mindfulness exercises and Cognitive Behavioral therapy interventions; referral processes; access to a directory of public mental health services.

3. Digital Phenotyping offered by the vendor, Mindstrong: Analyzes factors associated with cell phone usage (passive sensory data) to engage, and suggest behavioral activation strategies for users; informs targeted communities and recommended interventions; assists individuals at risk of, or experiencing early symptoms of, mental illness in identifying risks/symptoms or potential for relapse; tailors wellness strategies to a person's needs.

Back to Agenda

The Collaborative provides descriptions of the vendors on page 8 of the Reference Guide. The following table illustrates which mental health application components were chosen by the five (5) previously approved counties and the ten (10) current counties proposing to join the Collaborative:

Previously Approved	Commission Approval Date	Online Peer Chat and Support Groups	Virtual Therapy Using an Avatar	Digital Phenotyping/Wellness Monitoring
Los Angeles	October	X	X	X
Kern	October	X	X	X
Mono	February	X	X	X
Modoc	April	X	X	X
Orange	April	X	X	X
Proposing to Join				
City of Berkeley	September	X	X	X
Inyo	September			X
Marin	September	X	X	X
Monterey	September			
Riverside	September	X	X	X
San Francisco	September	X	X	
San Mateo	September	X	X	X
Santa Barbara	September	X		
Tehama	September	X	X	X
Tri-City	September	X	X	X

The Universal Components include the following:

1. Community Engagement and Outreach Engaging Users Promoting and Use: This component would provide a strategic approach to access points that will expose individuals to the mental health apps.

2. Outcome Evaluation: An evaluation of all elements of the project, including measuring reach and clinical outcomes.

All counties participating in the Technology Suite Collaborative must include the universal outreach and evaluation components into their local projects.

CalMHSA will serve as the fiscal intermediary for mental health jurisdictions who are participating in the Technology Suite Collaborative. In this collaborative approach, CalMHSA will contract directly with all vendors and other necessary contractors. Currently, CalMHSA has contracted with the two application vendors, Mindstrong and 7 Cups; an outreach and marketing firm, Runyon Saltzman, Inc. (RSE); a privacy and security firm, Intrepid Ascent; and an evaluator, University of California Irvine.

To address variations in project duration amongst participating counties, CalMHSA will produce a contract amendment to extend the current term for all counties joining the Collaborative with a timeframe beyond the initial 3 years established as the demonstration project timeline by Los Angeles and Kern Counties.

Six (6) of the ten (10) Counties in Cohort 2 are electing to offer Mindstrong's digital phenotyping and wellness monitoring services to their clients: City of Berkeley, Inyo, Riverside, San Mateo, Tehama, and Tri-City. Riverside and Inyo Counties are both proposing to purchase additional clinical capability from Mindstrong. **The Collaborative may wish to explain the contracting process and safeguards in place for these two Counties offering clinical services through Mindstrong in addition to the digital phenotyping and how the two services will overlap.**

Identified Innovation and Strengths of adding Cohort Two to the Collaborative

The Collaborative asserts that the primary purpose of the Technology Suite Collaborative Project is to increase access to mental health services to unserved and underserved groups; and to increase the quality of mental health services, including better outcomes. *This project introduces a new approach to the overall mental health system including, but not limited to, prevention and early intervention.*

The Collaborative identifies the following strengths of adding additional counties to the Collaborative:

- Centralized contracting
  - Lessons learned from the first five (5) counties will streamline onboarding of next cohort
- Increased diversity of targeted populations, including:
  - Hearing impaired, criminal justice involved/re-entry, foster youth, visually impaired, pregnant and new mothers, populations with highest rates of suicide
- Increased statewide representation (see appendix for detailed map)
  - Added jurisdictions of very small, small and medium populations in new regions of the state
- Many counties are casting a "wide net" in order to reach the identified target populations but also reach additional unserved and underserved populations
- Additional application functionality for:
  - Smart referrals (highly customized local service recommendations)
  - Linkage with Wellness Recovery Action Plans
  - Evidence based practices (e.g. Dialectical Behavior Therapy)
  - Delivery of clinical services through a mobile application

Learning and Evaluation

Background and Program Evaluation Status

The Technology Suite Collaborative (the Collaborative) project aims to advance therapeutic technology platforms to expand the capacity and capability of county mental health systems in order to serve a myriad of individuals with an array of mental health needs.

While the Counties within this cohort have submitted separate learning and evaluation plans, this section will first describe the statewide learning and evaluation plan that will guide all individual county plans followed by a brief snapshot of the focus of each county in Cohort Two (**for a detailed overview of the statewide evaluation plan, see pages 108-133 of the Collaborative Reference Guide**).

Following the approval of Los Angeles County and Kern County's plan in October 2017, the Collaborative sought to accomplish a number of learning goals and outcomes with the implementation of the Technology Suite Project. *According to the Collaborative, implementation of the project took longer than expected, and none of the original project goals have been met to date*. Instead, the Collaborative has indicated that a number of other process-oriented and contractual accomplishments have been made, such as: hiring a project manager, selecting vendors, assisting other counties interested in joining the collaborative project, contracting with the University of California, Irvine (UCI) to evaluate the project, hiring a privacy and security consultant, as well as a marketing firm for outreach and engagement.

Since being selected to oversee the statewide project evaluation as well as serve to provide technical assistance to participating counties in July 2018, UCI has entered into an evaluation planning phase. Part of this planning phase has involved developing an evaluation strategy. The UCI evaluation team has proposed a two part strategy for the statewide evaluation of the Technology Suite Collaborative project that will examine the implementation and effectiveness of the project, described in the following section.

Collaborative Evaluation Plan

The UCI evaluation team has proposed utilizing a formative evaluation that will be guided by two strategies. The first strategy will utilize the Consolidated Framework for Implementation Research (CFIR), a determinant framework, in order to understand programmatic factors that contribute to outcomes. The CFIR framework has been identified as being useful for understanding the impact that an intervention has and why it does or does not work. The second strategy will utilize Glasgow's Reach Effectiveness Adoption Implementation Maintenance (RE-AIM), and effectiveness framework, which will guide how aspects of the implementation will be measured. The RE-AIM framework is utilized to better understand the factors that impact of the implementation on specified outcomes (**see pgs. 118-126 of the Collaborative Reference Guide**).

The formative evaluation will be guided by the goals, learning questions, and outcomes that were first laid out in Los Angeles County and Kern County's approved plan in October 2017. These goals, learning questions, and outcomes are noted below.

Collaborative Goals:

- Recognize and acknowledge mental health symptoms sooner
- Reduce stigma associated with mental illness as reported by users
- Increase access to the appropriate level of care
- Increase purpose, belonging, and social connectedness of individuals served
- Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

Collaborative Learning Questions:

1. Will individuals at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone applications?
2. Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
3. Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms, and increases in well-being?
4. What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
5. Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users?
6. How can digital data inform the need for mental health intervention and coordinate of care?
7. What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment?
8. Can we learn the most effective engagement and treatment strategies for patients from passive mobile device data to improve outcomes and reduce readmissions?
9. Can mental health clinics effectively use early indicators of mental illness risk or relapse to enhance clinical assessment and treatment?
10. Is early intervention effective in reducing relapse, reducing resource utilization, and improving outcomes? Does it vary by demographic, ethnographic, condition, intervention strategy, and delays in receiving intervention?

Collaborative Intended Outcomes:

1. Adherence to a treatment protocol
2. Improving safety
3. Increasing quality
4. Increasing access
5. Increasing treatment-seeking behavior
6. Reducing utilization
7. Improving recognition of and treatment outcomes for vulnerable or at-risk patients
8. Increasing community engagement and target population(s) reach

Methods:

A number of *methods* have been identified by UCI to meet the formative evaluation. In particular, organization surveys, semi-structured interviews and/or focus groups, fidelity monitoring with data mining, observations, and financial reports have been identified as methods to address the adoption, reach, and implementation of the project. To evaluate the effectiveness of the project, UCI has proposed utilizing individual surveys, data from app users, and research logs (qualitative feedback; **see pgs. 130-132 of Collaborative reference guide**). In addition to data that will be provided by participating counties, UCI will use data from a few different sources, including: the Office of Statewide Health and Planning (OSHPOD) to examine changes in emergency department use; data form the California Department of Health Care Services (DHCS) to examine claims and substance use services; as well as data from the California Health Interview Survey (CHIS) to examine measures of mental health, such as distress, access, utilization stigma, among others.

Additional measures that will be used to determine if the goals and outcomes of the collaborative project have been met include:

Collaborative Measures:

- Access to care
- Clinical outcomes
- Self-reported purpose, belonging, and social connectedness
- Consumer's ability to identify cognitive, emotional, and behavioral changes and act to address them
- Utilization rates
- Stigma associated with mental illness
- Comparative analyses of population level impacts (tech users vs. non-users)
- Penetration or other unmet need metrics

Cohort Two Plans

As a means of adding value, and expanding upon the original goals set out in the original plan, individual counties have submitted plans that seek to cast a wider net of what the statewide evaluation will cover. This section will cover the focus that each county seeking approval from the Commission seeks to provide.

City of Berkeley

Target Population:

- Youth and transition age youth (TAY)
- Individuals who aren't able to access services at Berkeley Mental Health
- Socially isolated individuals, including older adults or individuals with disabilities
- Those with sub-clinical mental health symptom presentation, including those who may not recognize that they are in the early course of a mental health condition
- Those at risk for mental illness or relapse of mental illness
- Those experiencing high frequency of inpatient psychiatric care
- Current behavioral health clients in need of additional support
- Family members of children and adults with mental illness in need of additional support

The City of Berkeley states that the apps will be available to all Berkeley/Albany residents, however, particular groups identified above will be of interest. While a broad focus will be on all residents within Berkeley/Albany, the City hopes to determine how best to improve the coordination and access to mental health resource information and ancillary services.

Inyo County

Target Population:

- Perinatal women; pregnant women that give birth at local hospital
- TAY

Unlike other participating counties, Inyo County will utilize the Mindstrong app to meet the needs of their target population in the county.
In utilizing Mindstrong's app alone, the County states that it will also allow them to explore the potential to integrate the Wellness Recovery Action Plan (WRAP) framework to make a larger impact on positive outcomes for individuals in the county with severe and persistent health challenges. **Because Inyo County will only use the Mindstrong app to meet their local needs, it is unclear as to how this specialized focus will meet the goals and outcomes laid out by the Collaborative.**

Marin County
Target Population:

- Individuals with sub-acute mental health symptom presentations, including those who may not recognize that they are experiencing symptoms
- Family members with either children or adults suffering from mental illness who are seeking support
- Socially isolated older adults, including those at risk of depression
- Clients or potential clients in outlying or rural areas who have difficulty accessing care due to transportation limitations
- Older adults who are at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness

Marin County will target a broad range of county resident, but will pay particular attention to the Older Adult population. In doing so, the County will not only meet the needs of this population, but also provide insight into the use of technology-based platforms and Aging Services Technology among older adults with depression and other chronic conditions.

Monterey County
Monterey County will target all individuals in the county that are in need of mental health services. Unlike other participating counties, however, Monterey County plans on leveraging the work of the Collaborative to develop a web-based screening tool that will assist individuals in understanding their needs, and connecting them to the appropriate services in a timely manner. **While this addition is an important development to meet local needs, and possibly be used across counties, it is unclear how the County will contribute to the goals and outcomes set forth by the Collaborative**.

Riverside County
Target Population:

- Early detection and suicide prevention
- High risk populations
    - First onset psychosis
    - Formerly incarcerated population (re-entry)
    - Full service partnership consumers
    - Individuals with eating disorders
- Underserved communities
    - Hispanic/Latino
    - American Indian
    - African American

- Asian-Pacific Islander
- LGBTQ
- Deaf and hard of hearing

Riverside County will offer technology services to all county residents, however, special attention will be paid to the three areas noted above. **The County may wish to identify data sources that will be used to determine whether or not the needs of these populations have been met—particularly formerly incarcerated**.
Of the target populations identified, the County states that feedback from stakeholders identified services for hearing and visually impaired communities as a priority. **The Collaborative may wish to address additional capabilities that will need to be developed to meet the needs of this community, if any**.

San Francisco County
Target Population:

- TAY population
- Diverse ethnic groups

The County will provide services to all county residents, but have identified TAY and diverse ethnic groups as needing particular attention. **The County may wish to clarify what populations make up "diverse ethnic groups."** Additionally, San Francisco County states that the project will focus on developing highly skilled peer specialist teams and training of behavioral health clinicians within the system to advance their skills in using and providing technology-based interventions to clients. The County has identified goals and outcomes that will contribute to the statewide evaluation. **The County may wish to identify how they will measure what they state will be the focus of their project—the development of peer specialist teams and training of behavioral health clinicians.**

San Mateo County
Target Population:

- Isolated older adults
- TAY in crisis
- Monolingual residents
  - Chinese
  - Spanish

The three focus areas above were identified as being unserved, underserved, or inappropriately served populations though their community engagement process. Along with providing the necessary data for the overall statewide evaluation, the County hopes to learn how the technology suite project can address the needs of monolingual residents, such as those residents who only speak Chinese or Spanish.

Santa Barbara County
Target Population:

- Individuals discharged from psychiatric hospitals and/or recipients of crisis services
- Adults living in geographically isolated areas
- TAY enrolled in colleges and universities at risk for severe mental illness and/or suicide

Through their project, Santa Barbara County seeks to learn how the use of the technology suite can improve the County's efforts around peer support services relative to prevention, early intervention, family support and social connection.
While their evaluation plan addresses how they will meet these local evaluative needs, **the County may wish to clarify how what is learned through their project will also contribute to the overall statewide evaluation.**

Tehama County
Target Population:

- Individuals in remote, isolated areas of the county
    - Isolated seniors
    - Isolated youth
- Youth and TAY
- Men at risk of suicide
    - Migrant workers

Through their local stakeholder process, Tehama County identified groups of residents that were either being unserved or underserved in the County. Particularly, the County identified the migrant worker population and adult men who are at risk for suicide as being of particular importance. The County states that the technology project may address these groups as they may be more willing to engage in private and confidential services through the use of the apps.

Tri-City
Target Population:

- College students and transition age youth
- Older adults
- Non-English speaking community members

Tri-City states that their project will meet the needs and increase access to groups that have been identified as underserved groups within the region (noted above). In addition to meeting individual client needs, Tri-City will provide specialized training to peers, volunteers, and community members that seek to become virtual support persons. Tri-City, in addition to meeting statewide evaluation needs, will seek to learn if the training provided not only enhances services by peers, but also if these trainings translate into better outcomes for consumers.

Comments

While a considerable amount of evaluation work has been accomplished to-date, many questions remain. Some questions are related to the capabilities and development of each app to meet local county needs (i.e. Riverside's focus on the hearing-impaired population), as well as how individual counties with unique and specialized plans will meet the needs of the statewide evaluation (i.e. Inyo County and Monterey County). While UCI has proposed an extensive evaluation strategy, this strategy does not clearly mirror the overall goals set out by the collaborative—some clarity in marrying the two is necessary. For example, the original goals of the project need to have clearly identified measures that will be taken from apps and other sources. **The Collaborative may wish to consider developing a simplified logic model that connects all learning goals, questions, and outcomes with measures and data sources.**

These questions and concerns have been shared with the Collaborative as well as the UCI evaluation team. According to UCI, the Collaborative is currently in a planning period consisting of meeting with individual counties to better understand the objectives each county has laid out, and how projects will be implemented. Additionally, a statewide advisory group is being developed to better inform the overall statewide evaluation. The completion of the planning period and a finalized evaluation plan is expected by the end of October 2018.

Undoubtedly much has been learned since the original Technology Suite Project was approved relative to implementation. Moving forward, in an effort to provide clarity and transparency, **the Collaborative may wish to consider preparing forward-facing documents that highlight process-oriented plans, goals, and objectives for the Technology Suite project**.

Privacy and Data

Universal standards around application based technology for mental health is an emerging field. Because universal standards are still in development, CalMHSA contracted with Intrepid Ascent to provide technical and legal expertise related to data sharing, privacy and security requirements, informed consent and other technical areas (for more details see pages 101-107 in Reference Guide).

Intrepid Ascent worked with CalMHSA to develop the information security and privacy contract included in the BAA (Business Associate Agreement) with each approved county. The BAA is part of a "Due Diligence" packet that will also be provided to each county in Cohort Two, if approved. These items included agreements about privacy and security that each county had to have their privacy officer and county council review and agree to the standards. **Commission staff have not yet seen a copy of the BAA or the "Due Diligence" packet.**

Data Storage and Access

Stakeholders have raised concerns about privacy and the security of data collected by the applications. Numerous news articles also raise concerns about data breaches and how data can be used. The Collaborative states that participating counties own their data and only the vendors, county staff/contracted providers, and the evaluator have access to it.

During a conference call with MHSOAC staff on August 29, 2018, Intrepid Ascent asserted that the security and privacy contract in the BAA meets legal standards and assured the security of data collected through the applications. To ease concerns and promote transparency, **the Collaborative is encouraged to outline how the privacy and security protections are put in place for this project, explain how legal standards were met and include them in a public facing packet.**

Informed Consent

The Collaborative states that a critical principle of their privacy and security plan is individual choice and that they are providing clients the opportunity to make informed decisions about their participation in the program and about how their data is collected, used, and disclosed to others. However, the process by which participants are notified of their choice to consent or not consent to the privacy plan involves prompting individual users to click through an acceptance pop-up within each of the applications**.** Los Angeles County states that they are adding a second layer of informed consent by having the clinician or personal services coordinator go over the applications with each client. **MHSOAC staff encourages the Collaborative to follow Los Angeles' example for all counties create a standard practice to have counties ensure that individuals are thoroughly informed of what they are agreeing to.**

Institutional Review Board (IRB)/Coordination of the IRB Process

The Collaborative states that the contracted evaluator, University of California Irvine (UCI) is working with all potential counties to individually assess the need for an IRB. UCI states that they believe the Tech Suite Collaborative projects falls under the category of quality assurance. UCI states that they began preliminary work and will formally file an IRB waiver to exclude the need for IRB review and approval with Human Subjects after the advisory group is formed and convenes.

County Specific Regulatory Requirements

The Community Planning Process

The process of joining an existing project as part of an effort to create a state-wide collaborative is not traditional and does not begin with a community generated idea. However, the counties proposing to join the Collaborative as Cohort Two have demonstrated that their local community planning processes have identified needs that the counties believe will be met by implementing this project at the local level. All counties in Cohort Two assert that their local communities support this project and many counties provided documentation demonstrating a robust planning period where community input directly defined which application components were chosen and which additional capabilities could be built out by the vendors to better meet the needs locally.

Comments

Overall, the counties met the regulatory requirements for their local community planning processes. Specific examples of note: *Marin County* is focusing on the older adult population and has planned focus groups to tailor the applications based on feedback.

Riverside County developed a plan specifically tailored to the needs and services expressed by over 1,000 consumers, peers, clinicians, family advocates, and general residents of Riverside County at multiple stakeholder presentations, focus groups, and information sessions regarding the Technology Suite. Riverside also worked specifically with the local hearing and visually impaired communities to develop application features to make the applications accessible.

San Francisco County met directly with the populations targeted by their plan: transitional age youth, and the transgender community. Feedback from both communities were in support of joining the collaborative and directly shaped the project proposal and vendor programming requests.

San Mateo County identified the populations of focus through 14 community engagement activities and shaped their proposal based on community feedback.

Tehama County received 275 responses by utilizing an online survey available in English and Spanish and accessible by smartphone. They also held targeted meetings with members representing LGBTQ+, transition age youth and adult community consumers in addition to four community stakeholder meetings throughout the county.

The Commission may wish to discuss a process for counties to engage in meaningful community planning in future collaborative projects like this one.

Stakeholder Feedback

All county plans were shared with MHSOAC stakeholders and no letters of support or opposition were received. However, the MHSOAC did receive the following email and letter from local stakeholders:

- An email from a stakeholder providing a “no confidence” vote against the Tech Suite Collaborative adding Cohort Two to the project.

- A letter from a local stakeholder in Try-City stating that the Technology Suite Innovation Project is not apriority for the residents in Tri-City and that they already have access to free mental health apps.

Back to Agenda

The Budget

COUNTY	Total INN Funding Requested	Duration of INN Project	Local Costs*	CalMHSA***	Technology Investment	Evaluation	% for Evaluation	Sustainability Plan (Y/N)	Funds Subject to Reversion (Y/N)
City of Berkeley**	$462,916	3 Years	$100,800	$18,146	$289,189	$54,781	12%	Y	Y
Inyo	$448,757	3 years	$165,000	$13,750	$253,129	$16,878	4%	Y	Y
Marin**	$1,580,000	3 Years	$725,334	$230,249	$544,957	$75,940	5%	Y	Y
Monterey**	$2,526,000	3 Years	$200,000	$113,800	$2,073,452	$138,748	5%	Y	Y
Riverside**	$25,000,000	3 Years	$3,221,761	$1,087,500	$16,613,279	$4,077,460	16%	Y	Y
San Francisco**	$2,273,000	3 Years	$915,091	$372,163	$738,357	$247,388	11%	Y	N
San Mateo**	$3,872,167	3 Years	$1,046,500	$424,623	$2,183,884	$217,158	6%	Y	Y
Santa Barbara**	$4,912,852	5 Years	$1,895,670	$81,923	$2,510,528	$424,731	9%	Y	N
Tehama	$118,088	2 Years	$0	$29,644	$64,500	$23,944	20%	Y	Y
Tri-City**	$1,674,700	3 Years	$831,700		$843,000		0%	Y	Y
Total	$42,868,480								

*May include Personnel, Equipment, Administration and local contracting
** Inludes paid peers
***May include Outreach & Marketing, Experts and CalMHSA Overhead

Sustainability Plan

All counties have indicated that if the project is deemed successful, they will identify alternative funds (CSS, PEI, absorb into existing programs, etc.) to sustain the services.

Funds Subject to Reversion (AB114)

Santa Barbara and San Francisco Counties are NOT using any funds subject to reversion for this project. All other counties are.

Comments

Tri-City is encouraged to identify the amount of funding allocated to CalMHSA and the evaluation.

Riverside County may wish to discuss how their investment in local customization of the available applications will provide access for underserved populations and add value to the statewide collaborative.

Additional Regulatory Requirements

All individual counties seeking to join the Collaborative project as Cohort Two, appear to have met the minimum regulatory requirements listed under MHSA Innovation regulations. As indicated, there are numerous areas of the overall collaborative that may need to be addressed moving forward.

If the Collaborative Innovation Project is approved, the MHSOAC must receive the certification of approval from both *Riverside County and San Francisco County's* Board of Supervisors before any Innovation Funds can be spent.

Back to Agenda

References

California Mental Health Services Authority (2018). *Collaborative Reference Guide*. Retrieved from https://calmhsa.org/wp-content/uploads/FINAL-3.pdf

Full project proposals can be accessed here:

http://mhsoac.ca.gov/file/city-berkeleyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/inyocountyinnplantech-suite08232018finalpdf

http://mhsoac.ca.gov/file/marincountyinnplantechsuite2018finalpdf

http://mhsoac.ca.gov/file/montereycountyinnplanscreening-timely-assessment2018pdf

http://mhsoac.ca.gov/document/2018-09/technology-suite-collaborative-project-plan-riverside-september-2018

http://mhsoac.ca.gov/file/san-francisco-countyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/sanmateoinnplantech-suite2018finalpdf

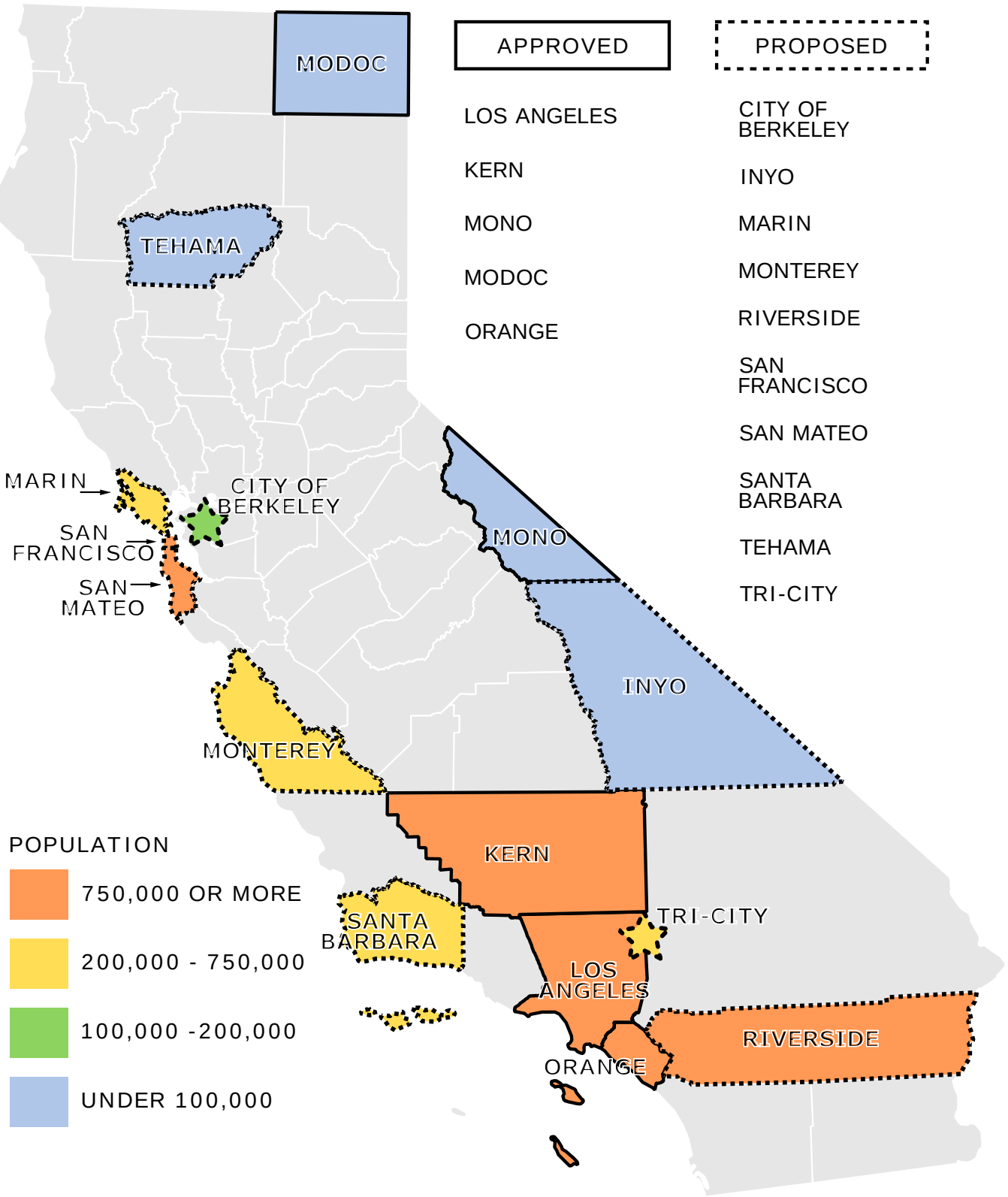
http://mhsoac.ca.gov/file/santabarbaracounty-innplantech-suite08232018finalpdf

http://mhsoac.ca.gov/file/tehama-countyinn-plantech-suite2018finalpdf

http://mhsoac.ca.gov/file/tri-cityinn-plantech-suite2018finalpdf

Back to Agenda

Appendix
Map of Previously Approved Counties and Counties Proposing to Join



Back to Agenda

County Behavioral Health Technology Collaborative

"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

INTRODUCTION

With its resources, diversity and collaborative orientation, the California Public Mental Health system has the opportunity to lead the way in using mobile-phone based applications to fundamentally transform how we serve a large, diverse population with an otherwise large unserved and under-served need. To this point, the progress of Kern, Los Angeles, Modoc, Mono and Orange counties (Cohort #1) over the last 10 months, has set the Technology Suite Collaborative well on its way to demonstrating that the public mental health delivery system can drive advancement of technologies that are low cost and high value and generate benefit to communities beyond their traditional service-delivery scope.

As proposed by the initially approved counties, Los Angeles and Kern, the primary purpose of this collaborative MHSA Innovation Project is to increase access to mental health care and support and to promote early detection of mental health symptoms or predict the onset of mental illness. At this stage, ten additional counties/cities (Cohort #2) seek to join the collaborative to pursue the following shared goals:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness as reported by users
3. Increase access to the appropriate level of care
4. Increase purpose, belonging and social connectedness of individuals served
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

Since the MHSOAC's approval in October 2017 for Kern and Los Angeles counties to initiate and form the foundation for this statewide innovation collaborative, the "Tech Suite" has made steady progress towards engaging targeted populations with mobile technologies. During July 2018, Cohort #1 counties conducted targeted small scale 'launches' of an initial application (7 Cups) and similarly are currently conducting targeted deployment for a second application (Mindstrong). Based on learning from this 'soft launch' of 7 Cups, these counties are currently undertaking an expanded outreach and marketing to individuals currently served by their delivery systems. As experience and learning is gained, each county will continue to incrementally expand their outreach and marketing of 7 Cups and clinical integration of Mindstrong.

This progress is the result of many critical activities and accomplishments since initial approval:

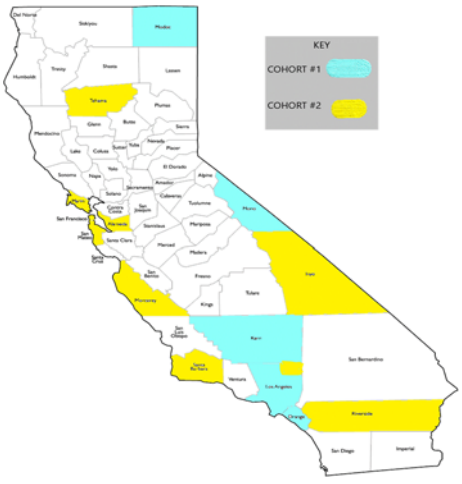
- Selection of an initial set of applications (7 Cups and Mindstrong) and preparation of those apps for county-specific deployment;
- Engagement of local peers and end users in the app selection process and launch readiness activities;
- In depth investigation of privacy and security requirements to develop appropriate safe guards for user information (e.g. contractual requirements, privacy policy, guiding principles);

- Development of the central role of peers in the engagement of end-users as well as advancement of application (app) design;
- Selection of a highly qualified evaluator (University of California, Irvine) who is designing and preparing the formative evaluation of the collaborative innovation (See Attachment IV for the Evaluation Learning Objectives and over-arching Logic Model that will drive UCI's evaluation);
- Creation of implementation pathways for selected apps that will streamline and facilitate these efforts in future counties;
- Initiation of a statewide brand development process that will generate both broad brand recognition and population-specific relevance (e.g. sub-branding); and,
- Initiation of culturally and linguistically accurate translations of the 7 Cups apps into Spanish and Vietnamese with statewide partners, while creating the methodology for comparable translation for all participating counties' threshold languages.

See Attachment I for a detailed chronology of milestones and collaborative progress of counties approved to date.

As described in greater detail below, Cohort #1 has developed the foundation for selecting, marketing and securely deploying mobile applications. While this first group of counties will continue to expand the use of apps in their communities and for identified target populations, their progress has successfully set the stage for a 2nd cohort of counties to join the collaborative. Cohort #2 counites will be able to leverage this foundation to expand the Tech Suite's effectiveness for additional population segments, as well as to advance application features/functions to better link with the public mental health system's needs, strengths and capabilities. Their participation will also assure the Tech Suite is developed in the context of the real-world challenges of a statewide approach; in other words, they will help assure this innovation identifies and builds the necessary infrastructure and technical knowledge to make mobile applications viable across the breadth and depth of the need in California's public mental health system.

The value of an expanded collaborative is underscored by a core learning to date: the experience of one population segment using mobile applications is not predictive of all populations. Therefore, it is anticipated that an expanded collaborative will identify populations for whom mobile applications are effective – as well as for those whom they are ***not***. Both outcomes are equally valuable in terms of setting the stage for statewide deployment of mobile applications.



Counties (and cities) seeking to join the Tech Suite at this time are: Berkeley (City of), Inyo, Marin, Monterey, Riverside, San Mateo, San Francisco, Santa Barbara, Tehama, Tri-City (Pomona, LaVerne and Claremont). The total Innovation funding requested by these counties/cities is approximately $32,000,000. See Attachment II for a table of "Cohort #2" counties/cities, including key demographics, summary of stakeholder activities and total funding requested.

In arriving at this proposed use of innovation funds, each of these counties has undertaken extensive community planning processes that have:

- Identified local mental health needs in the community;
- Examined whether mobile digital technologies can help address those needs;
- Delineated specific populations to target with mobile applications and associated desired outcomes from their use; and
- Designated learning objectives for joining and contributing to the Tech Suite innovation.

Further, each county's involvement represents the opportunity to advance the depth and breadth of the Tech Suite's innovation and associated learning, demonstrate for whom and in what manner digital technologies can successfully address mental health concerns, and to set the course for the statewide deployment of this new modality.

EXPANDING THE COLLABORATIVE: CREATING THE OPPORTUNITY FOR LARGE SCALE CHANGE

The proposed addition of 10 counties/cities to the Tech Suite Collaborative is focused on opportunities in four areas:

Cohort #2 Opportunities:

- *Diversify conditions for learning*
- *Create parity in access to mobile applications*
- *Target outreach and support for specific populations in need*
- *Expand application functionality to increase effectiveness*

- *Diversify conditions for learning:* The health care field has a history of long delay in innovative practices becoming available to all or most whom could benefit from them. Too often, they reach only small populations served in highly specialized programs. Experience reveals this is often due to those interventions being developed under 'laboratory-like conditions' that do not readily translate to the size, diversity and constraints of real-world environments. The addition of Cohort #2 counties to the Tech Suite represents the opportunity learn how to use mobile technologies at the scale and variety reflective of California – and to set the stage for much faster and pervasive spread of this new modality where it has proven efficacy.

- *Create parity in access to mobile applications:* Cohort #1 counties have demonstrated that the considerable 'barriers to entry" for the deployment of mobile applications become manageable and affordable when undertaken in a collaborative structure. The cost of expertise, hands-on learning, and the applications themselves is substantially reduced when shared; similarly, associated learning curves are shortened. Counties seeking to innovate in the area of digital technologies and who are not allowed to join the collaborative are disadvantaged in their local pursuit. This is especially true for small counties who simply could not undertake this innovation as a solo entity; the cost to acquire and innovate is too high. As such, Cohort #2 counties are seeking parity in access to this innovative approach.

- *Target outreach and support for specific populations in need*: As already indicated, the core pursuit of Cohort #2 counties' proposed innovations is to deploy mobile applications for a diverse set of target populations. As such, their involvement will drive the use and refinement of apps for a variety of communities served by the public mental health system that Cohort #1 counties are not going to reach. The addition of a second cohort will significantly diversify the app use by for high need and/or hard to reach populations. See Attachment III for a table of Cohort #2's target population.

- *Expand application functionality to increase effectiveness:* The direct influence of the public mental health system on the design of mobile technologies represents a next phase in the evolution of digital therapeutics for individuals with mental health concerns. From leadership to front line staff to peers and stakeholders, the deep knowledge of individuals involved in the specialty mental health field is a largely untapped reservoir, in terms of drivers of application design and deployment. Improving mobile applications for use in the public mental health system is a fundamental benefit associated with Cohort #2 counties joining the Tech Suite.

In summary, Cohort #2 will: 1) increase the impact of the selected apps, in terms of size and diversity of populations reached, 2) expand the relevance and effectiveness of the apps to the public mental health system, and finally 3) deepen the necessary learning to support statewide deployment.

INNOVATION OPPORTUNITIES FOR COHORT #2

Innovation is possible when there is an environment for learning and the resources (funding, skill, know-how) to act on that learning. Each instance a county joins the collaborative, both of these elements grow and there exists an opportunity to explore new possibilities and greater effectiveness for those served. Currently, within Cohort #1, counties consistently benefit from shared learning and gain considerably from the collaborative process – and so are experiencing both of these benefits. Cohort #2 counties are positioned to benefit from Cohort #1 counties, from counties within their own cohort – and they will in turn provide benefit to Cohort #1 counties.

The counties in Cohort #1 are currently driving innovation on a variety of fronts, including the collaborative methodology itself, which has resulted in the Tech Suite becoming its own 'innovation platform'. This positions Cohort #2 to generate even more innovation in two categories: 1) customization and tailoring for additional, highly specified target populations, and 2) expanded and refined application functionality. Examples of planned innovation associated with the next 'cohort' of counties to join the Tech Suite include:

Target Populations	App Functionality
o hearing impaired o criminal justice involved o visually impaired o pregnant and new mothers	o 'smart' referrals (highly customized local service recommendations) o linkage with Wellness Recovery Action Plans

o transgender youth o isolated seniors o *others we cannot predict!*	o linkage with evidence-based practices (e.g. Strengths Model) o *others we cannot predict!*

See Attachment III for a table of the counties' needs, target populations, innovations, aims, etc.

EVALUATION: CAPTURING LEARNING AND MEASURING IMPACT

The Tech Suite has selected a single qualified vendor (University of California, Irvine) to conduct a formative evaluation of the statewide implementation of the innovation, as well as for each participating county. A formative evaluation is the chosen approach as it is a "rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts." The goals of the formative evaluation approach which match the needs of the Tech Suite evaluation include:

- Developmental: plan for successful uptake of an intervention by clearly defining the problem and understanding its context, designing or adapting an intervention to address a problem and utilizing an implementation framework to anticipate negative unintended consequences, and understanding the organizational context (e.g. readiness) and stakeholder perspectives on a planned intervention;
- Implementation: help ensure a project is successfully implemented by monitoring key indicators, work with stakeholders to pivot/change/adapt as need arises to respond to both internal and external factors;
- Interpretation: create generalizable knowledge for how to successfully implement the intervention in other settings.

Since joining the Tech Suite, UCI has worked rapidly to develop a plan for this evaluation. After in-depth planning sessions with each county and each application vendor, the UCI team has developed a detailed logic model and an overarching plan. (See Attachment IV for a table of the learning objectives and working draft of the logic model.) While conducting this planning, the UCI evaluation team has also been and continues to monitor launch activities underway in Cohort #1 counties to initiate data collection, to capture early learning and to gain baseline measures as feasible.

COLLABORATIVE CAPACITY

As described above, the Tech Suite's collaborative approach creates a variety of opportunities and benefits for participating counties. Some of the most immediate benefits are increased choice (for mobile applications), accelerated learning in use of this new modality for mental health supports, and cost sharing. Key cost sharing opportunities are:

- Pooling funds for shared needs (procurement and contract administration, evaluation, outreach and marketing, and other technical expertise);
- Technology fees adjusted by county-specific MHSA fund allocation levels; and,
- Prevention of duplicated overhead and administration associated with local deployment of apps.

This collaborative and shared cost structure is making the development and operation of technical infrastructure more affordable and easier with each successive county and cohort that joins. Below is an outline of functional areas and infrastructure that have been developed and continue to be refined through Cohort #1 efforts. Given the diversity of counties in Cohort #2, their involvement will strengthen this infrastructure and further reveal individual county and shared capacities necessary to support this modality on a large scale. The following table describes Cohort #1 progress in these functional areas and how Cohort #2 will benefit from them.

Technical Support & Function	Cohort #1 Progress and Resulting Cohort #2 Opportunities
Application Procurement, Management & Advancement	• Cohort #2 counites will "inherit" the procurement of 7 Cups and Mindstrong applications, as applicable to the intentions of each. The CalMHSA contracts with these vendors are designed to apply to any county who joins the collaborative and executes a Participation Agreement with CalMHSA. Cohort #2 counties proposed budgets reflect this existing contracted fee structures, which are based on a sliding scale (based on MHSA funding allocation by the State). • Cohort #2 counties who elect to procure a new application will have the benefit of considerable learning and enhanced capability to solicit, evaluate and contract with new vendors.
Outreach & Marketing	• Cohort #1 has developed initial marketing materials that will serve as templates for each Cohort #2 county, shortening the process to develop them. • Cohort #1's current effort to develop a Tech Suite brand and image will be complete in late 2018 and so will be ready for use by Cohort #2 from the outset of their marketing. • Cohort #1 is developing a graduated or incremental approach to marketing each application, and as such is creating a pathway that Cohort #2 can both benefit from and build upon.
Peer Involvement	• With the support of 7 Cups and the CalMHSA team, Cohort #1 has developed job descriptions and training processes for counties' paid Tech Suite peers. Cohort #2 will be able to use these tools for streamlined recruitment and preparation of their local peers – as well as provide further refinement of this critical role. • During this developmental phase of the Tech Suite, CalMHSA is recruiting a state-level peer lead role. This individual will be hired and ready to support Cohort #2's local peers and their central role in linking and engagement.

Technical Support & Function	Cohort #1 Progress and Resulting Cohort #2 Opportunities
Clinical Integration for Wellness & Recovery	• Cohort #1 counties have begun mapping how each application will integrate with their clinical processes, an activity that will continue throughout the collaborative to assure integration is achieved in all desired clinical settings. While progress to date will give Cohort #2 a strong starting point, this is an area in which the second group of counties will advance the learning and innovation to the benefit of all counties involved.
Evaluation & Performance Management	• As proposed and required for an MHSA innovation, Cohort #1 has selected an evaluator (UCI) and supported development of a plan to evaluate this project, including both the statewide and county-specific impact and learning. Cohort #2 counties will benefit from an evaluation methodology that is designed and ready to address their county-specific outcomes and learning objectives. • The localized, unique goals of each county will generate learning and insight critical to meeting the needs of California's diverse population and supporting statewide dissemination and adoption of mobile technology as a new and invaluable modality for the public mental health system. As such, this will enrich evaluation findings.
Privacy & Security Monitoring, Safeguards	• As one of the most critical areas of learning and infrastructure development, establishing the privacy and security of end user's personal health information has been a big part of Cohort #1's initial efforts. The considerable due diligence completed has resulted in the following references to assist each county and the suite as a whole in assuring the privacy and security of end user information: o Privacy & Security Guiding Principles o Template Business Associate Agreement o Information Security and Privacy Requirements o Privacy Policy o (Draft) Technology Framework and Security Plan • This thorough 'due diligence' and investigation into the needed safeguards allows each new county to initiate their internal reviews and considerations from the outset of participation, allowing plenty of time for inquiry and sign-off by local authorities. • With the addition of Cohort #2 counties, the Tech Suite has the opportunity to establish statewide standards for privacy and security related to mobile application use in general (not just for this innovation). This is not expected to be a one-time effort, but rather an ongoing process to assure changes in technology are translated into necessary changes in privacy and security.
Accounting & Contract Management	• Throughout all of the above activities, the contract monitoring and administration capabilities have been developed and continue to be refined by the CalMHSA team of staff and contractors. This will allow Cohort #2 counties to benefit from the following newly developed supports: o Budget planning and monitoring; o Participation Agreement administration;

Technical Support & Function	Cohort #1 Progress and Resulting Cohort #2 Opportunities
	o Vendor workorder development and management (to translate Innovation proposals into vendor-specific requirements); o Accounting and budget variance reporting; o Project management support via Smartsheet and other collaborative activities; and, o Access to subject matter experts.

In summary, what the expansion of the Tech Suite Collaborative represents is a chance to use the innovation platform that has been built by Cohort #1 counties to gain the necessary learning about how and for whom the public mental health system can deploy digital technologies to cost-effectively address large and persistent levels of under and unserved mental health needs.

Back to Agenda

"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

Attachment I - Cohort #1 Progress/Milestones

TIMEFRAME	ACTIVITY / OUTCOME
Oct 2017	**Collaborative Development:** • Kern and Los Angeles Counties submit proposals to the MHSOAC for a statewide collaborative Innovation project • MHSOAC Commissioners approved statewide collaborative and two inaugural counties to create the foundation for the collaboration
Nov – Dec 2017	• **Collaborative Development & Approach:** • CalMHSA engaged to provide administration of the statewide collaborative • CalMHSA assigned staff to begin Tech Suite vendor acquisition activities
	Technology, Evaluation, Outreach & Marketing Procurement: • RFSQ developed and distributed for 5 tech components of the tech suite • Panel convened to review submissions to identify set of qualified vendors in each component category • Qualified vendors selected in the following categories: o Digital Applications (5 vendors) o Outreach and Marketing (1 vendor) o Evaluation (2 vendors)
Jan – Feb 2018	**Collaborative Development & Approach:** • Mono County submits proposal to the MHSOAC to join the collaborative • Opportunity to join collaborative shared with CBHDA Governing Board • MHSOAC Commissioners approved Mono County to join collaborative
	Implementation: • Collaborative Project Manager hired through CIBHS • Plan for collaborative infrastructure developed • Detailed infrastructure development launched • Individualized county development launched (per existing plans)
Mar – Apr 2018	**Technology Procurement:** • Prequalified vendors given a project orientation • Each vendor conducted an in-person demo and presentation of their apps for teams from initial 3 counites, including peer representatives • County staff and peers practiced with pre-qualified apps to identify initial set of apps • Initial vendors and apps selected: ***7 Cups, Mindstrong*** • Selected endors provided initial planning contracts to support readiness work
	Collaborative Development & Approach: • Modoc and Orange counties submitted proposal to the MHSOAC to join the collaborative • Monthly call launched for county MHSA Coordinators across the state to support their community planning efforts and Innovation proposal development • MHSOAC Commissioners approved /Modoc and Orange Counties to join collaborative • CalMHSA executed Participation Agreement with Los Angeles and Kern Counties

TIMEFRAME	ACTIVITY / OUTCOME
	• Learning from initial counties regularly shared with interested counties to increase their understanding of the opportunity and promote greater readiness once approved
	Outreach and Marketing: • Based on limited respondents to initial RFSQ in Nov. 2017, a focused RFP is issued for an outreach and marketing vendor • RFP resulted in 15 letters of interest and then 5 proposal submissions.
	Evaluation: • RAND engaged to assist with approach to evaluation, including development of over-arching approach and critical qualifications and capabilities of collaborative evaluator. • Collaborative determined to proceed with a follow-up Request for Qualification (RFQ) to select an evaluator to support development of evaluation plan as well as conduct the actual evaluation.
	Peer Roles: • Participating counties began preparation of their plan to engage peers to support individual use of apps, as well as inform needed improvements and advancements to those apps • County leads reached out to and engaged initial peer reps into planning activities.
	Implementation: • Budgeting and pricing methodology created to support flexible, formula driven contracts with vendors driven by size of participating county, desired level of customization and allocation of funds for shared needs as well as local supports. • Vendors oriented to formula driven approach to pricing that enables periodic addition of counties to their contract without re-contracting for each county • Supported new counties in their budget planning per slide fee schedule based on county size
May – June 2018	**Privacy and Security:** • The Tech Suite conducted search for agency with technical, legal and operational experience with data sharing and associated privacy and security concerns • Intrepid Ascent worked with The Tech Suite and vendors to determine needs and approach to privacy and security across the elements of the project • ***Intrepid Ascent*** engaged to support development of privacy and security guidelines, associated vendor contract requirements, contract language for data owner ship and intellectual property, as well as informed consent • Intrepid Ascent develops initial "Privacy and Security Guidelines" and "Clinical Integration and Data Sharing Continuum" to inform data sharing
	Technology Procurement: • The Tech Suite worked with Intrepid Ascent to develop contract for app vendors that support complexity of the project, including: privacy and security issues, customization for specific county size and needs, informed consent and other unique terms and conditions • App vendor contract developed to reflect the aims, legal complexity, and privacy/security of the collaborative developed, including a Work Order to link each county's Innovation Proposal and Participation Agreement with the Vendor Contract
	Peer Roles • The Tech Suite supported a shared learning process to identify the roles of peers in each county's deployment of apps

TIMEFRAME	ACTIVITY / OUTCOME
	• Counties to evaluated opportunities for existing peers and peer network to support outreach and engagement of target populations (See Section 4 of the Resource Guide) • Individual counties appointed their lead peers for the project • Individual counties, worked with 7 Cups and their local peers, develop the Tech Suite (paid) Peer role and plan recruitment • Individual counties identified existing peer network and plan to engage these individuals in marketing and support of app use
	Outreach and Marketing: • A Tech Suite independent panel reviewed proposals received in response to RFP and identified a recommended vendor (RSE) • RSE worked with app vendors and counties to develop initial marketing outreach materials (shared and customized per county) • RSE oriented project to brand development process • Leadership from initial 5 collaborating counties accepted CalMHSA panel recommendation and ***RSE*** awarded outreach and marketing role • RSE created prototype handout cards and flyers to be customized for each county • RSE developed an expedited branding process to generate collaborative brand and awareness campaign
	Evaluation: • The Tech Suite issued a focused RFQ to pre-qualified evaluator candidates to gain deeper understanding of each agency's capabilities • The Tech Suite convened an independent panel to review RFQ responses and develop recommendation for selection • Demographic reporting requirements (per MHSA Innovation regs) provided to app vendors • Leadership from initial 5 collaborating counties accepts CalMHSA panel recommendation and ***UCI*** awarded evaluator role • App vendors developed method to gain demographic information from end-users in an engaging, person-centered way (to be tested by peers to finalize)
	Implementation: • Cohort #1 carried out detailed readiness work to support initial "soft launch" of the apps in July and then steady expansion after initial debugging • The Tech Suite advanced infrastructure development to support county and vendor contracting, budgeting and associated transactions • Counties developed initial plans and readiness associated for their Soft Launch in July
	Collaborative Development & Approach: • Tech Suite convened a day-long kick-off session for initial counites (cohort #1) • Tech Suite supported Innovation proposal development, including budgets aligned with vendor contracting strategy • Over 100 staff, peers and stakeholders convened in Los Angeles in a shared learning session focused on target population needs, relevant app-based solutions, and IT concerns

TIMEFRAME	ACTIVITY / OUTCOME
	• Over 20 counties indicated interest in joining the collaborative with at least 12 planning to submit Innovation proposals to the MHSOAC in order to join as part of "Cohort #2" • CalMHSA executed Participation Agreements with Orange, Mono and Modoc Counties
July – Aug 2018	**Implementation:** • 7 Cups launched customized app in Cohort #1 counties
	Outreach and Marketing: • Counties initiated outreach and marketing efforts for 'soft launch' and plan expanded outreach and marketing to support next phase of implementation
	Peer Roles: • Initial local paid peers hired • State-level Peer Lead job description developed, and job notice posted
	Evaluation: • UCI began development of evaluation plan, including conducting in depth orientation with each county and app vendor
	Collaborative Development & Approach: • Counties in Cohort #2 received support to maximize readiness for implementation activities once approved to join the collaborative
	Technology Procurement: • App vendor contract finalized; formal contract monitoring initiated
Sep - Oct 2018	**Implementation:** • Each county is implementing Mindstrong in a small scale to generate learning about how to link client use of the Health app with clinician use of the Care app
	Outreach and Marketing: • Each county is initiating 'internal' marketing of 7 Cups as the next milestone in deployment of this app
	Peer Roles: • Newly hired Tech Suite peers are being trained to support marketing/outreach and app use • Local peers in existing networks to be trained to support use of apps by individuals they assist
	Evaluation: • UCI is developing comprehensive evaluation plan • UCI is convening a Tech Suite Evaluation Advisory to review/approve the evaluation plan and then monitor evaluation • UCI is collecting initial data associated with current small scale launch of the apps • App vendors are developing project-wide and county-level dashboards and other analytics
	Collaborative Development & Approach: • CalMHSA is preparing for an all-county, all-vendor in-person learning session in Fall 2018 to support transfer of Cohort #1 counties knowledge to Cohort #2 counties and to support all counties planning their next steps to expand (Cohort #1) or initially launch (Cohort #2)
	Adapting to Local & Population Needs: • 7 Cups working with RSE and their partners to develop translation of their app content; initial translations will be Vietnamese and Spanish

Back to Agenda

County Behavioral Health Technology Collaborative

"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

Attachment II – Cohort #2 Counties

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
	#	% of CA			
Berkeley	121,874	.31%	• Berkeley and Albany are diverse communities with changing demographics. In each city the African American population has decreased in recent years while the Latino and Asian populations have both increased. • Both cities have large student populations, including Albany Village, providing housing for many of University of California's foreign students and their families. • Threshold languages include English, Spanish, Farsi, Cantonese, and Vietnamese, and approximately 28% of Berkeley and 40% of Albany residents speak a language other than English at home. • Each city is comprised of the following racial and ethnic demographics: BERKELEY: 61% White; 8% African American; 20% Asian; 11% Hispanic/Latino; <1% American Indian/Alaska Native; and <1% Native Hawaiian/Pacific Islander (P.I.). ALBANY: 54% White; 4% African American; 27% Asian; 13% Hispanic/Latino; 1% American Indian/Alaska Native; and 1% Native Hawaiian/Pacific Islander (P.I.).	• In FY16/17 a CPP process was conducted which included community input meetings, key informant interviews, focus groups and MHSA Advisory Committee meetings. • Program ideas that could potentially address the needs that emerged from this CPP Process were then vetted through MHSOAC staff, and the MHSA Advisory Committee before proposing to join the multi-county collaborative Technology Suite Project. • In FY17/18 a second CPP was conducted to obtain input on the proposed use of INN funds to join the multi-county collaborative Technology Suite Project. This included MHSA Advisory Committee meetings, Community Input Meetings, and presentations at meetings of the Berkeley Pool of Consumer Champions, and the Mental Health Commission. Broad outreach was also conducted to share information/obtain input on demonstrations of the proposed technologies. Total outreach on this proposed project reached an excess of 100 individuals which included a diverse group of consumers, family members, MHSA Advisory Committee members, representatives from community-based organizations, individuals from un-served, underserved and inappropriately served populations; City Commissioners, Berkeley Mental Health staff, and other MHSA Stakeholders.	$462,916
Inyo	18,577	.05%	• With 10,000 square miles, Inyo is the second largest county in California, but with a population of only 18,800 has the smallest number of persons per square mile and is one of the smallest of the small counties population-wise. • Inyo has the highest elevation in the United States, Mount Whitney, and the lowest elevation, Bad Water in Death Valley. • Only about 2% of the land is privately owned with a majority of the land being National Forest and Park, Bureau of Land Management, and Department of Water and Power. These contrasts mean that for funds that are disbursed by population and other such formulas, Inyo relies on "minimum-based allocations" in order to run programs. • Ethnicity: 66% identify as white alone; 19% identify with Hispanic or Latino origin, 13% identify as American Indian; 2% identify as Asian; and less than 1% identify as African American. 4% of people identify with 2 or more races. Spanish is the threshold language.	• ICHHS/BH held stakeholder meetings with staff from several health agencies as well as with participating perinatal or expectant mothers to see if the proposed project was relevant to their needs and experience. Stakeholders filled out a preliminary survey and the results were used in program planning. • Our stakeholder surveys will address the MHSA standards to see if there is a community partner that hasn't yet been included in our planning and dissemination process, review the cultural competency component for our participants to see what additions need to be made, regularly survey of consumers and consumer-identified friends and family who also download the app to capture their voice, and see if the addition of Wellness Recovery Action Plan education and processes to onboarding in the app helps clients feel the service is centered around recovery and resilience principles.	$448,757
Marin	236,886	.66%	• Marin County has a median age (46.1) almost 10 years older than the state as a whole (36.4) • 30% of Marin adults 65 or older live alone. • Marin is composed of 71% white, 16% Latino, 5% Asian, 2% Black residents • The top income families earn over 21 times more than low income families in Marin County. • Communities of color experience poverty at disproportionate rates.	• To find an innovation solution to meet the mental health needs of older adults, two large community meetings were held (November 27, 2017, and December 13th, 2017). 63 people attended the community meetings, and 48 demographic sheets were collected; 46% identified as clients/consumers and family members. Participants represented veterans, law enforcement, mental health consumers and family members, mental health providers, health and social service providers, and individuals with disabilities.	$1,580,000

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
	#	% of CA			
			• Marin City is predominantly African American and has a poverty rate of 33% compared to 8% poverty rate county-wide	• Feedback from the initial community meetings included finding a solution that could serve as many older adults as possible rather than a more targeted approach for a limited number of older adults. However, people also highlighted that homebound or isolated seniors and caregivers should be prioritized. • In January, the Mental Health Advisory Committee was presented with the ideas and feedback from the stakeholder meetings and helped narrow the ideas down. • After the community meetings and Advisory Committee review, a series of key informant meetings with providers and advocates for older adults were held in March and April to discuss potential solutions including the Technology Suite. • Mental Health Advisory Committee and other stakeholders were then invited to participate in a Tech Suite Demo with 7 Cups on Friday, April 27th, or Friday, May 4th.	
Monterey	443,281	1.11%	• Monterey County has four geographic regions: o The Salinas Valley, the Coastal Region, North County and South County. The Salinas Valley region is comprised of the City of Salinas and immediately adjacent towns. o The Coastal Region encompasses all cities on the coast from Marina to Big Sur and includes Carmel Valley. o North County is made up of the small, rural and/or agricultural towns and districts north of Salinas. South County is the expansive area of Monterey County south of Salinas. South County is the expansive area of Monterey County south of Salinas. o The South County region consists of several larger cities with populations above 15 and 30 thousand people, as well as several remote, sparsely populated rural districts. As the City of Salinas is by far the most populous area of the county, its region has a corresponding majority of beneficiaries. • Alternatively, the combined cities of the Coastal Region that total a population size close to that of Salinas has a proportionally low number of Medi-Cal beneficiaries. • The relatively small North County region has an equal proportion of beneficiaries, while about 1 in 5 Medi-Cal beneficiaries in Monterey County are found in the expansive South County region. • As the "safety net" mental health care provider, being aware of the geographic distribution of Monterey County's highest-needs populations is critical for effective planning and service delivery. As the "safety net" mental health care provider, being aware of the geographic distribution of Monterey County's highest-needs populations is critical for effective planning and service delivery. Monterey County is the 3rd largest county by land mass in the state, and has four geographic regions: 1. The Salinas Valley, the Coastal Region, North County and South County. The Salinas Valley region is comprised of the City of Salinas and immediately adjacent towns.	• Community planning process activities supporting this innovation began in spring of 2017 and were carried out as part of the MHSA 3-Year Program Plan and Annual Update planning processes. In total, this innovation project was informed and refined by community stakeholders through a series of 13 focus groups with 232 participants, and community survey with 214 respondents, and 4 community workshops with 114 individuals. Spanish translation and interpretation services were provided in all community engagements. Mora than half of community engagement occurred in communities or organizations with majority Hispanic/Latino populations.	$2,526,000

County	Size* #	Size* % of CA	Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
			2. The Coastal Region encompasses all cities on the coast from Marina to Big Sur, and includes Carmel Valley. The combined cities of the Coastal Region that total a population size close to that of Salinas has a proportionally low number of Medi-Cal beneficiaries. 3. North County is made up of the small, rural and/or agricultural towns and districts north of Salinas. 4. South County is the expansive area of Monterey County south of Salinas. The South County region consists of several larger cities with populations above 15 and 30 thousand people, as well as several remote, sparsely populated rural districts. As the City of Salinas is by far the most populous area of the county, its region has a corresponding majority of beneficiaries. The relatively small North County region has an equal proportion of beneficiaries, while about 1 in 5 Medi-Cal beneficiaries in Monterey County are found in the expansive South County region. Demographically, Monterey is reflective of California with a majority Hispanic/Latino population and an aging population. The general population characteristics of the county are: o Median Age: 33% o Children & Youth: 23% o TAY: 15% o Adult: 46% o Older Adult: 17% o Hispanic/Latino: 57% o White: 32% o Asian: 6% o African American: 3% o Other: 2% The economy of Monterey County is primarily supported by agricultural activities, tourism and the public sector (i.e. local government and military agenices).		
Riverside	2,415,955	6.07%	• 4th largest county in California by population and by land area • Riverside County is roughly the size of the State of New Jersey, containing frontier, rural, and metropolitan population densities, resulting in plan implementation barriers of small, medium and large counties combined • Riverside County ranked 3rd in population growth in counties nationwide; the only California county to make the list of "Top 10 Gainers" in the last US Census Bureau report • Estimated by 2025, Riverside's population will grow to 2,692,006 (California Dept. of Finance) • Diversity: 48% Latino/Hispanic; 36% Caucasian; 6.4% African-American; 6% Asian/PI. • Riverside County Dept. of Public Health (2014) estimated the LGBT population between 71,000 to 236,000, potentially making this community the 3rd largest minority group in Riverside County • Riverside County is home to one of the two schools for the deaf in California. Estimated population of deaf individuals nationally is 10%; Riverside County estimate is 17%. • 38% of Riverside County residents were living at or below 199% of poverty in 2016 • Older Adults (age 60+) represents 20% of the population	Over 1,200 individual stakeholders • 2 Adult System of Care Committee mtgs • 2 Behavioral Health Commission mtgs • 1 Center on Deafness Inland Empire staff mtg • 2 Children's Committee mtgs • 1 Criminal Justice Committee mtg • 2 Cultural Competency Reducing Disparities Committee mtgs • 1 Deaf Awareness Week event • 1 Desert Regional Board mtgs • 1 Eating Disorder Collaborative mtgs • 1 Inland Empire Kindness Campaign mtg • 1 Legislative Committee mtg • 2 May is Mental Health Month Fairs – Western and Mid County Regions • 1 Mid County Regional Board mtg • 1 Model Deaf Community Committee • 1 NAMI San Jacinto mtg • 1 Older Adults System of Care Committee mtg	$25,000,000

e Technology Suite" Cohort #2 Proposal Brief to the Mental Health Oversight and Accountability Commission

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
	#	% of CA			
			• TAY (age 16-25) represent 15% of the population	• 2 Riverside Resilience community mtgs • 11 TAY Collaborative meetings – Desert, Mid, and Western County Regions	
San Francisco	883,963	2.22%	For cities with over 200,000 people, it is the second most populated city in the country, second only to New York. San Francisco is diverse, and has a minority-majority population, with around 33% of its population being of Asian descent, 15% Latinx, and only 41% of its population is non-Hispanic White	• Visitacion Valley Service Providers • Sunset Mental Health Center Service Providers and Community Advisory Board members • Excelsior Family Connections Chinese families and staff • San Francisco LGBT Center • Curry Senior Center: Mental Health Services Act Advisory Board meeting • Transitional Age Youth Full Service Partnership Meeting • Richmond District Neighborhood Center Service Provider Meeting • Department of Rehabilitation Co-op Administration Meeting • San Francisco Veterans Town Hall Meeting • Excelsior Family Connections Spanish Speaking Families and Staff Meeting • San Francisco Behavioral Health Services Adult/Older Adult Service Providers Meeting • Asian Pacific Islander Wellness Center: Transgender Program Community Members and Service Providers • Rafiki Coalition: Black/African American Community • Huckleberry Youth Programs: Transitional Age Youth Service Providers Meeting • Crisis Intervention Training Meeting Workgroup: Law Enforcement, Peers and Service Providers • San Francisco Behavioral Health Services Mental Health Services Act Advisory Committee Meeting • San Francisco Public Library: Combined Mental Health Services Act Provider and Advisory Committee Meeting • City College of San Francisco Health Education Department Workforce Development Networking Session • San Francisco Behavioral Health Services Client Council	$1,357,909
San Mateo	774,155	• 1.94%	• Diversity: o 39.5% White o 27.8% Asian or Pacific Islander o 24.8% Hispanic or Latino residents • Over 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well". • Threshold languages are Spanish, Tagalog, Chinese (Mandarin and Cantonese) and Russian. Concentration languages include Tongan and Samoan • One of the larger suburbs on the San Francisco Peninsula.	• In the spring of 2017, San Mateo hosted two public meetings, a CPP Launch Session and a CCP Prioritization Session. Over 270 participants were in attendance, and 156 demographic sheets were collected; 37% identified as clients/consumers and family members. Participants represented groups set forth in the MHSA legislation, including homeless individuals, law enforcement, mental health clients/consumers and family members, mental health providers, health and social service providers, and individuals with disabilities. • In April and May of 2018, San Mateo began a Community Planning Process that included 14 community meetings aimed to (1) inform community members about proposed the Technology Suite INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about the Innovation Projects and the Mental Health Services Act to ensure their ability to	$2,825,667

County	Size* #	Size* % of CA	Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
				meaningfully participate. See Appendix 2 for all materials developed for stakeholder engagement.	
Santa Barbara	453,457	1.14%	• Santa Barbara County is part of California's central coast, between Ventura County to the south and San Luis Obispo County to the north. According to the US Census Bureau, as of July 1, 2017, the population of Santa Barbara County was 448,150. A mid-sized county, Santa Barbara County ranks 19th in population size among all California counties. The US Census for 2011 identified the three largest cities as Santa Maria (North County), 99,553; Santa Barbara (South County), 88,410; and Lompoc (Central County), 42,434. • The overall county Latino population was 41.9% in 2010, and this number has increased to 45%. The percentage of Santa Barbara County residents who are Latino increases as one heads north. For example, Santa Maria's population is 70.6% Latino. • In recent years, Santa Barbara County has become increasingly diverse. Significant micro-communities are growing, encompassing various groups, including indigenous Oaxacan/Mixteco-speaking migrants and immigrants from central and South Asian countries, including China, the Philippines and Thailand. • The county's only non-English threshold language is Spanish.	• During community Innovation brainstorming sessions held from September to November 2017, stakeholders were asked for innovative project ideas based on addressing service gaps and affirmed that online technology could help improve access for key populations and enhance peer opportunities. • Stakeholder suggestions included implementing new computer applications and using digital communication that appeal to youth and hard to reach populations outside of the largest cities in the county. • Between November 1, 2017 and April 24, 2018, the proposed Technology Suite was discussed at 12 stakeholder forums held throughout the County. Approximately 620 individual stakeholders were invited to each of these forums, and a total of 120 attended.	$4,912,852
Tehama	64,039	.16%	• Poverty: At 22%, the percent of people living in poverty Tehama County is twice the state (16%) and national averages (15%). • Geographic isolation: 60% of Tehama County residents live in unincorporated areas compared to 14% of California. At 2,950 square miles, geographic distances within the county itself are significant. The county is placed within an isolated region, with travel to the closest major urban area, Sacramento three hours by car. Public transportation options are limited. • Limited transportation options: Because of the County's size and lack of public transportation, travel is private-vehicle dependent. As noted, the Tehama County has a significant poverty rate. Poverty, geographic barriers, lack of public transportation and large distances result in transportation becoming an economic challenge and a barrier to care. • Workforce shortage: Tehama has significant behavioral health workforce shortage. As a behavioral health employer, the county struggles to find and retain behavioral health staff. • Stigma discourages individuals from seeking services: Stigma and a lack of understanding about of mental illness symptoms are challenges for Tehama County. Individuals can be wary of using services in a small, deeply interconnected county where maintaining anonymity and/ or privacy may seem difficult.	• Initiated with restructuring of the subcommittee included increasing and deepening the committee's membership, and membership includes adult consumers; families of consumers; seniors; law enforcement; local NAMI; director-level staff of public medical, substance abuse and child protective services; Latino; LGBTQ+; K-12 educators and administrators; health care; social services; faith-based organizations; local non-profit service providers; advocates. • The subcommittee met and recommended a draft Community Participation Plan for Mental Health Board approval. • A series of four widely-publicized public community stakeholder meetings in diverse county locations, two with bi-lingual Spanish support. Each meeting lasted 1.5 hours. • A series of targeted meetings including LGBTQ+, transition age youth consumers and adult consumers. Each meeting lasted 1.5 hours.	$118,088
Tri-Cities	225,393	.57%	• The combined demographics for three cities includes 57% Latino, 26% White, 9% Asian Pacific Islander, 6% African American, 2% multiracial and less than one percent American Indian. • Roughly, 48% of the Tri City population speaks monolingual English, while 42% speaks Spanish as the primary language at home. Another 6.7% speak an Asian Pacific Islander language as the primary language, and 3.5% of the population speaks a language other than the ones already named.	• Innovation workgroups were convened beginning in November 2017 • In March 2018, this project was presented to stakeholders over the course of two MHSA meetings where the approval response was, again, overwhelming. • In preparation for this project, Tri-City conducted several focus groups targeting populations including foster care youth, older adults, LGBTQ, monolingual Spanish speakers and peers participating in the Courageous	$1,674,700

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed INN $$
	#	% of CA			
			• Forty-three percent of the population has an income that is less than 200% of the federal poverty threshold. • With a population of almost 220,000, Tri-City is considered a mid-size county with two unique statistics: 1) our three cities are home to four universities with a combined student population of over 45,000; and 2) our combined older adult population is 19%, which exceeds the same population in Los Angeles County of 15%.	Minds Speakers Bureau. Additional focus groups are scheduled and outcomes will be available upon request. • The MHSA Public Hearing was held on May 16 and hosted by Tri-City's Mental Health Commission at the La Verne Community Center. Over 130 individuals attended this annual event consisting of community stakeholders, professionals, faith-based organizations, and local schools and colleges located in the cities of Pomona, Claremont and La Verne. The Innovation project was approved by the Commission and then presented to the Governing Board and adopted on June 20, 2018.	

*Source: California Department of Finance Demographic Research Unit
Report E-4, Population Estimates for Cities, Counties, and the State, 2011-2018, with 2010 Benchmark, Released: May 1, 2018
County and State Population Estimates, 2011-2018, with 2010 Benchamark
Cities, Counties, and State Population Estimates, 2011-2018, with 2010 Benchmark
For more information: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/
Data Prepared by: Demographic Research Unit California Department of Finance

Back to Agenda

County Behavioral Health Technology Collaborative

"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

Attachment III – Cohort #2 Innovations

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
Berkeley	• Support wide array of individuals with mental health supports who do not qualify for intensive mental health services. • Meet the needs of both a large TAY population (including students of University of Berkeley and Berkeley Community College) and a growing senior population. • Provide low cost high impact mental health supports, as the need for supports far outweighs the available resources.	• Increase Access to/Availability of Services for Various Populations: Ex. Access to services for individuals in middle income group who make too much money to qualify for Medi-Cal, but not enough to pay for a private Mental Health provider; Bilingual individuals; undocumented individuals; Clients who reside in Albany; Individuals with less severe Mental Healthissues, isolated individuals, etc. • Increase Coordination of Services and Transitions • Address Stigma: Including cultural stigma related to seeking out Mental Health services. • Provide additional supports for TAY/Youth Mental Health Needs	• Isolated individuals (including senior citizens) who may have one or more disabilities; • Transition Age Youth • Individuals who are in need of mental health services and supports but don't meet the eligibility criteria to receive services at Berkeley Mental Health.	Work with the vendor to have all local mental health and ancillary services available in one place on an accessible App.	• Test whether having an accessible mobile/computer App of resources increases access to mental health services to various populations that are not currently served at Berkeley Mental Health • Assess whether providing an App that would assist individuals in recognizing signs and symptoms of mental health concerns, would promote better outcomes. • Assess whether technology-based services would Increase the coordination of accessible information of area mental health resources; • Test whether technology-based services will provide better coordination of care for clients who are accessing multiple social services, promoting community collaboration and better mental health outcomes • Assess whether the utilization of technology-based services will reduce stigma around accessing mental health services; • Assess whether the provision of technology-based services will increase access and promote better mental health outcomes for transition age youth.
Inyo	• While national statistics show that between 50-80% women feel a short-term depression related to hormonal shifts after giving birth, 1 in 5 new mothers experience more severe and longer lasting depressive symptoms ranging in a spectrum of perinatal mood and anxiety disorders (PMADs) that can occur up to a year after giving	• Users report Mindstrong increased their awareness of their own wellbeing, and active steps they can take to support it. • Users report that Mindstrong removed mental health access barriers such as concerns about stigma and confidentiality.	• New mothers • Youth prior to transitioning out of high school	• Clients are able to view their brain biomarkers on their phone whenever they would like, and they can permit a select friend or family group to monitor this information via smart phone as well if they would like to flex their personal resource network prior to clinical contact.	• Test how digital phenotyping technology can be harnessed to provide a new tool for prevention or early intervention with some underserved populations in our county. • A successful pilot program with positive outcomes for perinatal mothers and transition age youth in

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	birth. Other than a single Postpartum Support International volunteer who covers both Inyo and Mono counties, Inyo does not have a dedicated infrastructure to support this group of women who are already statistically less likely than men to have an unmet need for mental health treatment according to CalMHSA's "Monitoring California's Mental Health" study of CHIS data published by Rand in 2018, which found that women needing treatment for a mental health issue were less likely to receive it than their male counterparts. • For Inyo's transition-age youth (TAY) population, pressures associated with transitioning from high school to secondary education or the work force can be amplified by Inyo's 4-5 hour geographic isolation from populous urban centers in any direction. This causes many contemplating a move toward independence to struggle with anxieties about navigating freeways, crowds, and urban systems without any previous experience. For youth deciding to stay in Inyo for their early adulthood, trying to find a living wage job and rent in an inflated housing market can seem just as daunting. These normal stresses can prove overwhelming when combined with an individual's physical and mental health struggles.	• Families and friends synced to a patient's alerts report they have observed benefits in improved recovery times, mood stabilization, or willingness to reach out for support. • The integrated WRAP approach increases users' sense of control and agency in their own recovery. • Users report that Mindstrong normalized their experience of depression or anxiety and decreased their sense of isolation. • Perinatal clients perceive the personal benefits of Mindstrong so clearly, they would recommend Mindstrong to their family and friends, or utilize Mindstrong again themselves during another pregnancy and perinatal event. • Higher percentages of high schoolers using Mindstrong maintain their grades, sports eligibility, and graduate at higher rates than high schoolers opting out of Mindstrong participation. • A percentage of high school graduates continue to use the application as part of an ongoing support strategy.		• Incorporate WRAP principles and educational support tools into the care offered through this tech to increase our understanding of how client-developed and client-driven tools enhance consumer satisfaction and engagement.	Inyo with this technological approach that lays the foundation for spreading this tech to an even more diverse field clients with a variety of behavioral health needs. • Because this technology holds the potential to signal patients (and their self-determined sphere of care) that early, accurate signs of out both the local and global implications related to this project. • Relapse, remission, or even efficacy of treatment are occurring, it also could reduce the high cost of care associated with higher levels of intervention that occur in cases where prevention and early intervention opportunities go unnoticed.
Marin	• Seniors in the county face barriers to accessing mental health services including: o seniors in Marin City and other areas in the county report encountering stigma around accessing mental health services o seniors in geographically isolated areas such as West Marin report difficulty getting to and from services	Amongst older adults: • Decrease in utilization of emergency services • Increased social connectedness, belonging and purpose • Reduction in symptoms of depression, anxiety and other mental health concerns • Increased ability to age-in-place, reduction in residential placements	Older adults that are underserved because of geographic, physical, economic, language or cultural barriers to accessing services	• Technology-based multi-county collaborative project that focuses specifically on older adults • Utilizing a locally developed training curriculum on mental health in older adults as an outreach and engagement strategy for the tech suite	• Will older adults either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application? • Will the use of virtual peer chatting and peer-based interventions result in users [older adults], reporting greater social connectedness, reduced symptoms and increases in well-being?

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	o homebound older adults or those with limited mobility across the county find their options to be limited • Older adults and their caregivers are at increased risk for depression because of social isolation and loneliness	• Increased public awareness of mental illness in older adult population and reduction in stigma Amongst families and caregivers: • increased capacity to support their older adult family member			• What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support, specifically in the older adult community? • For each of the above learning questions, what are the most effective engagement and treatment strategies for sub-categories of older adults (i.e. ages 65-75, Vietnamese, caregivers, etc.)
Monterey	Monterey County has a critical need to increase services the underserved Latino communities. As stated in the FY18-20 MHSA 3-Year strategic plan, MCBH has a goal to increase the service utilization rate of Latino's by 7% by the end of FY20. As the safety net provider for mental health services, Monterey County Behavioral Health (MCBH) looks to the Medi-Cal eligible population as a proxy for determining where needs are greatest in our community and how MCBH services may be best directed. Service utilization data has consistently indicated the Latino population to be drastically underserved, as they represent 75% of the Medi-Cal eligible population and comprise 54% of beneficiaries served by MCBH.	Develop a new web-based screening tool that to help individuals understand their potential needs and quickly connect them to appropriate treatment. Desired outcomes: • Increased access to mental health services in Monterey County (new clients) • Increased number of referrals into MCBH systems of care • Demonstrated accuracy in prescribing appropriate mental health service needs • Reduction in MCBH clinical staff time billed for evaluation/assessment services • Increase in clinical staff time billed for therapeutic treatment services	All County Populations	Develop a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the MCBH system. The tool will be developed to: • Screen for a broad range of disorders, from low-risk with mild need to severe with urgent need. • Easy use by community-based providers to help individuals understand the need for treatment. • Maintain confidentially standards. • Interface with MCBH's Avatar electronic health record system to provide more seamless transitions into care. • Work fluidly in Spanish. • Incorporate perspectives from the Latino community and will include cultural nuances that reflect how Latinos understand and relate to mental health. • Build upon current evidence-based screening tools with proven validity, and utilize item response theory to minimize the number of questions involved in the assessment.	• Determine if this screening tool accurately gauges type and severity of mental illness. • Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible. • Assess whether this web-based screening tool reduces the hours and cost associated with in-person assessments. • Assess the impact the implementation of this application has on the total volume of clients entering ACCESS services, including its effect on the demographics of clients served. • Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources. Many local agencies expressed interest in testing this, including local law enforcement who hope to use this to link community members to care.
Riverside	• Service to Hearing and Visually Impaired Communities: National studies indicate that approximately 10% of the total population is deaf. In Riverside, that number is estimated to	• Early Detection • Suicide Prevention • Improve Outcomes for High Risk Populations	• Early Detection o TAY • Suicide Prevention o Men over the age of 45 o Adults over the age of 65	• TAY Drop-in Center "Technology Ambassadors" o TAY members, as PSS interns (with stipends) report to a full-time PSS employee, become Tech	• Determine if the peer chat feature will increase accessibly to the hearing and visually impaired communities. • Determine whether digital phenotyping create better outcomes

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	be 17%. Though traditional avenues of recruiting ASL speaking employees, having deaf and hard of hearing representation at our advisory committees and the use of ASL interpreters are unutilized to engage this population, the hearing impaired remain underserved. During our most recent Public Hearing, the visually impaired community also advocated for improved services for their unique engagement and service needs. • Better Outcomes for Higher Risk Populations: o First Onset: The State is prioritizing the detection and treatment of first onset psychosis as a State-wide standard in Prevention and Early Intervention. Research indicates that prodromal signs of the illness can be detected and early intervention can delay the disorder. o Re-Entry: Riverside County has one of the highest parolee populations in the State. The criminal justice reentry population is at high risk of failing to connect with behavioral health services upon discharge from jail in addition to being at high risk for homelessness. Moreover, the re-entry population has exceptionally high rates of behavioral health need. o FSP Consumers: Full Service Partnership (FSP) programs are designed to serve consumers who have the highest service utilization and the greatest risk for relapse. We have traditionally not done well at engaging this population and the consequences of a lack of service results in repeated arrests, acute	• Improve Service Access to Underserved Communities and for Rural Regions, Mid-County and Desert Regions	o TAY • Improve Outcomes for High Risk Populations o **Re-entry** Consumers (AB109, Whole Person Care) o FSP Consumers o Eating Disorder program consumers • Improve Service Access to Underserved Communities and for Rural Regions o **Deaf** and **Hard of Hearing** o Ethnic cultural and LGBT communities o Mid-County and Desert Regions	Suite experts and serve as presenters and coaches o Partner with our cultural communities advisory groups to present Wellness Education at community identified venues o Serve as coaches or tech use consultations to any program or consumer utilizing the Tech Suite • Care Plan Tools for FSP, Re-entry Programs, and Eating Disorder program o Introduced to program participating consumers as an additional service option • Allied Health Care Partnership in Rural Communities o Primary Care and Urgent Care Education Program on Serving BH Consumers o Education provided by Peers and Clinical Educator o Participating allied providers will have access to use Tech Suite with their clientele • Outreach and Engagement o Wellness Technology community presentations at locations related to target populations o Engagement tools for PEI Promotores and Community Health Promoters programs o Program participation tools for PEI Specialized Ethnic Community Initiatives programs	for higher risk populations: onset; re-entry; FSP consumers; eating disorders; and, suicide prevention. • Determined if using artificial intelligence that is culturally tailored increases to traditionally underserve communities? • Determine whether the use of technology eliminates some of the barriers to access that rural and frontier communities encounter. • Determine if the inclusion of TAY Ambassadors is useful in the integration of behavioral health technology.

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	hospitalizations, and chronic homelessness. o Suicide Prevention: In Riverside County, males died at greater rates than females due to self-inflicted injury. • Eating Disorders: Better Outcomes for Consumers with Eating Disorders: Though the therapeutic professions have grown more sophisticated in serving people with eating disorders, the disorders remain challenging to treat due to the co- morbid physical health problems that result from the disorder, as well as the addictive dynamics that often fuel the disorder in secrecy. • Geographic Service Barriers to Rural and Frontier Communities: Riverside is a diverse county consisting of metropolitan, rural, and frontier regions. For some areas, access to services can be extremely difficult due to a lack of resources and transportation issues. In small towns, limited surrounding services decrease the potential for consumer engagement due to stigma and the possibility of the town hearing about the behavioral health needs of individuals. If there is only one access point to services, anonymity and privacy are impacted.				
San Francisco	• Feedback gathered through the Community Planning Process (CPP), which included specific outreach to and inclusion of the transgender community, resulted in expressed needs and support for peer mental health support and information about up-to-date local resources through an online platform. • A main finding from an intensive Transitional Age Youth (TAY) strategic planning process was that the TAY population has internal barriers to	• Increased purpose • Increased feelings of belonging • Increased social connectedness • Increased quality of life • Reduced stigma of mental illness • Increased wellness	All San Franciscans with an emphasis on transition age youth (TAY) ages 16-24 and socially isolated transgender adults.	• The use of technology as a tool to connect individuals to mental health support and services is a new approach to overall public mental health service delivery as well as a focus on technology solutions for underserved groups.	• Will individuals who have accessed virtual peer chat services be compelled to engage in manualized virtual therapeutic interventions? • Will the use of virtual peer chat and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increased wellness? • What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?

e Technology Suite" Cohort #2 Proposal Brief to the Mental Health Oversight and Accountability Commission

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	receiving services including sensitivity regarding stigma for accessing services, mistrust of traditional service providers, not being aware of their need for services, and not being aware how to access services. • Through the CPP process, TAY were selected as the second target populations, as they would be likely to use technology to support their wellness and better connect with services.				• What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations (i.e. transition age youth, socially isolated transgender adults, others)? • Will issues pertaining to privacy and/or data security present a barrier to the use of these applications? • What percent of TAY and isolated transgender individuals feel satisfied with the engagement and outreach strategies?
San Mateo	Reach individuals not currently connecting with the public behavioral health system, specifically due to cultural and linguistic needs or finding it challenging to receive or access services in traditional office settings.	• Engage hard-to-reach and isolated residents in services • Connect them to in-person services if appropriate, promote social connectivity with peers • Mitigate the barriers of stigma for culturally specific communities.	• Transition-age youth in crisis • Isolated older adults • Monolingual Chinese and Spanish speaking	• Care coordination capacity to support the Chinese monolingual speaking community. • For youth in crisis, the capacity to identify and show on a local map, safe places for youth to go when in need was identified.	• Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services; • Does engaging with the apps promote access to mental health services and supports? • Does engaging with the apps effectively promote wellness and recovery?
Santa Barbara	• In FY 2016-17, adults discharged from a psychiatric facility waited, on average, six days to receive an appointment for mental health services. Engagement through online applications could assist individuals with a point of contact and support system immediately following hospitalization, ideally reducing the wait time for some individuals. • The Technology Suite could serve some of the individuals who, for a variety of reasons, do not attend appointments in a timely manner. For example, nearly 30% of the individuals requiring follow-up assistance following crisis care do not attend an appointment within 24 hours. The hope is that for many, comfort with	• Improve peer support services and access to care focused on prevention, early intervention, family support and social connection to reduce hospitalizations and use of emergency services among individuals 16 and older. •	Focus on at least one component of the Technology Suite –Peer to Peer Chat and Digital Therapeutics (PPCDT) – for three at-risk and/or underserved populations: • adults discharged from psychiatric hospitals and/or recipients of crisis services; • transition-age youth who are students at colleges and universities; and • individuals age 16 and over living in geographically isolated communities, such as Guadalupe, New Cuyama and others.	• Innovation funding offers Santa Barbara County its first opportunity to test the use of web-based peer-to-peer communications to promote greater access to peer support, behavioral health services and linkages to treatment. • The proposed project combines two powerful forces – peer support and digital technology – in the service of clients and the community. •	

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	using a computer or smartphone in a private setting will lead to prompt assistance and support.				
Tehama	• Geographic and socio-economic isolation. • Poverty. • A significant behavioral health workforce shortage. • Stigma.	• Detect mental illness earlier particularly among youth and transition aged youth (TAY). • Intervene earlier to prevent mental illness and improve client outcomes, particularly among youth and transition aged youth (TAY). • Provide alternate modes of engagement, support, and intervention among individuals living in remote, isolated areas and those who feel stigma in accessing traditionally-presented mental health services.	• Individuals in remote, isolated areas of the county; • Youth and TAY in all areas of the county who may be more comfortable accessing services using a tech-based and youth-culture oriented platform; • Those at risk of suicide who may be more willing to engage in private and confidential services, including adult men; • People who have not accessed services for whom a virtual mode of service may their needed threshold type to accessing support.	• Virtual support, information and/or care is likely to be a significant additional tool in addressing issues related to geographic and socio-economic isolation. • Another level of support for the Latino population. • The Tech Suite may address how best to reach out to and support youth and TAY in a mode that is most comfortable.	• Does a virtual platform reduce time from detection of symptoms to accessing care? • Can online social engagement reduce the severity of mental health symptoms among TAY/youth? Those living in remote, isolated areas? What is most effective in promoting the use of virtual care and support within TAY/youth and those living in remote, isolated areas? • What portions of the virtual platform show the most engagement by consumer group type (TAY/youth, geographically isolated and the rural Latino population, men at risk of suicide, others?) • What tools show the most efficacy, and how does that differ by client type?
Tri-City	• Multiple Innovation workgroups expressed concern for the younger population of the three cities, including college students and transition age youth (TAY) as well as older adults and non-English speaking community members. Focus groups targeting transition age youth from the Tri-City area reveal the stigma associated with receiving services in a traditional clinical setting is considered a challenge for many who then choose to forego treatment rather than risk the label of mental illness. Alternatively, it was noted that these same individuals have a strong connection to technology, including texting and social media. • By 2050, it is expected that the United States population age 65 and over will almost double in size. Accommodating the mental health needs of this growing population will require new	• Expanding access to services for TAY and college students by providing an alternative for those who are reluctant to seek services due to self-stigma. Address the early signs of mental illness to reduce hospitalizations and duration of mental illness. • Increase access to services for older adults; specifically those who are homebound and unable to access treatment due to health issues or lack of transportation. • Build strong relationships with monolingual Spanish and Vietnamese speaking populations who are considered unserved/underserved and experiencing barriers to services including language, distrust and fear due to immigration status.	Primary Population • Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners. • Older adults (ages 60+) who lack transportation or are unable to access traditional services. • Non-English speaking clients and community members. Secondary Beneficiaries • Peers, volunteers and persons connected with Tri-City who are interested in becoming trained virtual support persons and offering their support through chat or other technologies. • Current clients enrolled in services who are seeking additional sources of support.	• Peer College Liaison(s): College students with lived experience will focus on the outreach and engagement of students in need of support as well as develop relationships with mental health staff on each of the four college campuses. In addition, these liaisons will connect with other transition age youth in the community to create an awareness of these online support services. • Peer Older Adult Liaison(s): Older adults with lived experience who are able to foster relationships with other seniors who may feel isolated or reluctant to seek services, will visit senior community locations to help guide them through the process of identifying available treatment options both online and through direct care. • Peer Monolingual Liaison(s): Individuals with lived experience who are fluent in Spanish (or other non-	• Can the use of this technology enable our peers and volunteers to become trained listeners and use their lived experience to help persons struggling with similar life situations? • Does becoming a trained listener and participating in peer chats help our peers and volunteers in their path to wellness and self-development? • Will the capacity to chat in their native language attract unserved/underserved community members to use this technology? • Does participating in virtual chats or social engagement lead the consumer to use additional services from Tri-City such as visiting the Wellness Center, participating in groups or enrolling in services?

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	and innovative solutions. Two of the primary challenges include self-imposed isolation and lack of transportation. In response to this concern, Tri-City conducted focus groups in preparation for this project. Based on feedback received through surveys and older adult participants, 75% indicated they would be likely to seek mental health support if it was available online 24/7. • Finally, through the use of multi-language applications, Tri-City hopes to continue to expand our current language options for non-English speaking individuals who may consider this a viable approach to mental health support.		•	English language) and able to act as cultural brokers building trusting relationships with unserved and underserved community members in need of mental health support but experiencing barriers due to culture or stigma. • Specialized training or access to training for peers, volunteers, and community members who seek to become virtual support persons. In addition to training provided by the technology vendors, which will help peers to learn the basics of using the application and becoming online "listeners", peers will also have access to Tri-City sponsored trainings that include Cultural Competency, Motivational Interviewing, Community Resiliency Model, and Adverse Childhood Experiences. • Peers becoming paid listeners will be encouraged to leverage this employment experience as a stepping stone towards a career in a number of fields including customer service and peer advocacy. By expand the role of our current paid peers, we hope to create additional leadership roles and offer specialized training through our existing Peer Employment Program (PEP). In addition, each peer will have access to employment specialists located at our Wellness Center.	

Back to Agenda

"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

Attachment IV – Evaluation Learning Objectives and Logic Models

Target Audience: Are the apps reaching the intended target audiences, and has this initiative reduced known health disparities in access and/or outcomes?

EVALUATION OF THE IMPLEMENTATION STRATEGY: ADOPTION, REACH, MAINTENANCE		EVALUATION OF USER EXPERIENCE/USABILITY (1) Clinician (2) Patient/Client; (3) Listener		EVALUATION OF THE OUTCOMES/EFFECTIVENESS
Learning Objectives:				
Mental Health App Environment: (ENVIRONMENTAL SCAN) • What products exist with similar features to 7Cups and MindStrong? • Questions this can answer: What alternatives might users consider to 7Cups and MindStrong? • How do 7Cups and MindStrong compare to other apps in the market? • Questions this can answer: What is the market share of 7Cups and MindStrong to similar apps in the market? What features might people expect when using an app like 7Cups or MindStrong? What user experience might people expect when using an app like 7Cups or MindStrong? • What changes occur within 7Cups and MindStrong over time? • Questions this can answer: How might users experience with 7Cups and MindStrong change over time? How might users expectations of 7Cups and MindStrong change over time? County: • What are the <u>processes</u> that characterize the implementation of the Tech Suite at the county-level? • What are important or necessary <u>conditions</u> to support implementation and maintenance of the Tech Suite at the county-level?		County-Level Clinician: Clinician • *What are the factors that impact <u>use</u> of the Tech Suite at the **clinician** level?* a) What features / aspects of the apps facilitate or hinder use? b) How do clinicians engage with their patients on the app? c) How do clinicians use app data in assessment and treatment of their patients? d) What characteristics of the clinic environment promote effective use? e) How does their day-to-day job responsibilities affect use and vice versa? f) What things do they like / what frustrates them? Why? g) What changes would they make to better suit themselves / their patients? Client/Patient: Client/patient • *What are the factors that impact <u>use</u> of the Tech Suite at the **client/patient** level?* a) What features / aspects of the apps facilitate or hinder use? b) What characterizes users vs. non-users (abandoners)? / Who uses & how long?		How does use of 7cups and/or Mindstrong lead to the following: (LO1) Detect and acknowledge mental health symptoms sooner (LO2) Reduce Stigma associated with mental illness (LO3) Increase access to support and care (LO4) Increase purpose, belonging, and social connectedness (LO5) Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

- What are the important or necessary <u>resources</u> to support implementation and maintenance of the Tech Suite at the county-level?
- What characteristics of implementation at the county-level impact <u>outcomes</u> of the Tech Suite?
- What is the role of the peer recruiter in each county? What is their level of training? Describe activities? What audiences are they targeting and how? What is the effectiveness of their efforts? (align with RSE)

Clinic/Organization:

- What are the <u>processes</u> that characterize the implementation of the Tech Suite at the clinic/organization level?
- What are important or necessary <u>conditions</u> to support implementation and maintenance of the Tech Suite at the clinic/organization level?
- What are the important or necessary <u>resources</u> to support implementation and maintenance of the Tech Suite at the clinic/organization level?
- What characteristics of implementation impact <u>outcomes</u> of the Tech Suite?

User (County-Level Clinician, Patient/Client, Listener)

- *What are the necessary factors to support <u>adoption</u> of the Tech Suite at the **clinician** level? Who and at what level do clinicians adopt?*
  a) What are effective strategies in promoting clinician adoption?
  b) What factors support and hinder adoption? (Privacy? Context? Experience?)
- *What are the necessary factors to support <u>adoption</u> of the Tech Suite at the **patient / client** level?*
  c) How do clients interpret, reflect on, and use their data (Mindstrong / Growing Paths in 7 Cups)?
  d) How useful do they find the interactions with different clinicians / peers on the apps?
  e) How does the use of these apps impact interactions with their clinicians (if applicable)?
  f) How do the apps fit into their day-to-day lives?
  g) How does use impact stigma?
  h) What changes would they make? Why?

- *What characteristics of use/maintenance use impact **<u>outcomes</u>** of the Tech Suite at the **client/patient** level?*
  a) How does engagement / use impact the severity of mental health symptoms, social connectedness, stigma?
  b) What strategies contribute most to increasing an individual's capability and willingness to seek support inside and outside of the apps?
  c) How does their interaction with Peer Listeners influence perceived support, connectedness (7 Cups)?

7-cups Peer Listener: Listener

- *What are the factors that impact **<u>use</u>** of the Tech Suite at the **listener** level?*
  a) What features / aspects of the apps facilitate or hinder use?
  b) Why did they become a peer listener? What motivates them to be one?

a) What are the most effective strategies or approaches in promoting the adoption of apps and for which target audiences? b) What hinders adoption? (Privacy? Context? Stigma? Experience?) c) ***Non-adoption***: What are the characteristics of people who do not adopt the app? What are the reasons for not adopting?		c) Are they also clients (i.e., looking for support from others)? d) How do the apps fit into their day-to-day lives? e) What changes would they make? Why? • *What characteristics of use/maintenance impact **outcomes** of the Tech Suite at the **listener** level?* a) What qualities make an effective peer listener? b) How does interacting with clients impact peer listener's sense of belonging, purpose, stigma?		

Back to Agenda

e Technology Suite" Cohort #2 Proposal Brief to the Mental Health Oversight and Accountability Commission

TARGET AUDIENCES and EQUITY:

Are the apps reaching the intended target audiences, and has this initiative reduced known health disparities in access and/or outcomes?

EVALUATION OF THE IMPLEMENTATION STRATEGY: ADOPTION, REACH, MAINTENANCE

SYSTEM

OUTER SETTING:

Environmental Scan of Apps*

Environmental Scan of high profile events /larger context (e.g. high profile suicides, natural disasters, economy)

Impact of RSE Efforts (Engagement -> Outreach and Marketing)

Role of the Peer Recruiter?

Clinic/Organization

Non-Users: Who never adopts/uses the app(s)? Why?

User

Patient/Client

Peer

Clinician

(County- and Within App)

EVALUATION OF USER EXPERIENCE/USABILITY (1)Clinician (2) Patient/Client; (3) Listener

7-Cups

To live in a world where the human experience is free from stigma and stereotypes and rich with love and support. A world where all 7 billion of us can grow and feel like we truly belong

7-Cups Features:	Learning Objectives: Key Objectives Plus Additions	Kern	Los Angeles	Modoc	Mono	Orange
7 Cups Chat: (i) 1-1 anonymous peer-to-peer chat with an active listener [18-30]	(LO1) (LO2) (LO3) (LO4)	•	•			•
7 Cups Chat: (ii) Group Support- topically organized group support [18-30; 31-34]	(LO1) (LO2) (LO3) (LO4)					
7 Cups Chat: (iii) Noni -Emotionally supportive bot who attempts to develop alliance, and acts a "concierge." Note: she systematically encourages members to connect with others 1-1 to find and join a sub-community, to consider daily or regular check-ins with a support group to welcome support from others outside of 7 Cups [35-38]	(LO1) (LO2)					
7 Cups Community: Community – Information: (1) organized as topically organized threaded conversations, heavily moderated; (2) Daily Check-ins to increase self-efficacy; (3) Compassion hearts and forum up-voting	(LO4)	•	•			•
7 Cups Growth Paths: 32 different paths are based on different empirically supported evidence-based protocols https://www.7cups.com/supportGuides/selfHelpGuides.php ∞ Wellness Tests (Self-assessment on initial intake + every 20th growth path step; approximate 2-3 week interval) ∞ Readiness for Change - Prior to a Wellness Test, a user is asked about their readiness ∞ Gamification/ Reinforcement theory - acquiring badges and social signaling are reinforcing behaviors. ∞ Achievement-striving (component of Conscientiousness) may be underlying growth paths.	(LO1) (LO2) (LO3) (LO4)	•	•			•

MINDSTRONG

Our mission is to provide smarter, preemptive brain healthcare that improves clinical outcomes and reduces hospital visits

Mindstrong Features:	Learning Objectives: Key Objectives Plus Additions	Kern	Los Angeles	Modoc	Mono	Orange
Mindstrong Health: (i) measurement through passive capture of human computer interaction ("HCI") data [1-14]	(LO1)	•	•			•
Mindstrong Health: (ii) biomarker visualization that enables measurement based psychoeducation through telehealth (AI Engine) [15,16]. A. The digital biomarkers measure early client changes in cognition and mood indicative of risk for disorder onset, symptom changes, relapse, and remission [1,2,12-14]. B. The AI Engine outputs daily prognostic risk predictors used by the Provider in the Care portal to triage the care for population of clients.	(LO1) (LO2) (LO3) - Build engagement - Improve insight	•	•			•
Mindstrong Health: (iii) secure peer pairing, information and digital biomarker sharing with friends and loved ones [16]	(LO3) (LO4)					
Mindstrong Care: (iv) telehealth features to increase access to care including assessment, treatment, medication management/monitoring, continuing care, education and collaboration through provider-facing web app [17]	(LO3)	•	•			•
Mindstrong Health Services: Certified care professionals provide (i) the first-line triage for clients who are identified as at high-risk for clinical deterioration and/or disease progression based on the digital phenotyping results, in order to detect and acknowledge mental health symptoms sooner [1-14] and to reduce stigma associated with mental illness [15,16]; and (ii) targeted secondary evaluation, care management, clinical intervention, and/or referral to another mental health provider as appropriate to increase access to support and care [17]	(LO1) (LO2) (LO3)					•

EVALUATION OF THE OUTCOMES/EFFECTIVENESS

USABILITY

Bounce Rate

Retention Rate

App session interval

Average time spent

Features most used
Use tied to effectiveness

User satisfaction

Context of Use

Quality of relationships

Who stops using the app(s)? How long do they use them? Why?

(LO1) Detect and acknowledge mental health symptoms sooner

(LO2) Reduce stigma associated with mental illness

(LO3) Increase access to support and care

(LO4) Increase purpose, belonging, and social connectedness

(LO5) Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

DATA STRUCTURE AND DASHBOARDS

Back to Agenda

AGENDA ITEM 7

Action

September 27, 2018 Commission Meeting

Naming of the Fellowship Programs

Summary: The Commission will consider nominations for honorary naming of the Fellowship Programs.

Background: Assembly Bill 1134 (Gloria), Chapter 412, Statutes of 2017 authorizes the Commission to establish a Mental Health Policy Fellowship for a mental health professional and a mental health consumer. These Fellowships create an opportunity for collaborative learning for the Fellows, the Commission and stakeholders. These Fellowship Programs will expand opportunities for consumers and practitioners to inform the work of the Commission and public policy, while creating professional opportunities for consumers and practitioners to be exposed to the policy process and the work of the Commission. The Fellowships will enhance opportunities for the Commission to understand new and emerging challenges facing California's mental health system through the lens of practitioners and persons with lived experience. On August 21, 2018, the Commission received a letter from the Steinberg Institute requesting the Fellowship Program be honorarally named after Sally Zinman, and Rusty Selix. A copy of the letter is enclosed for your review.

Presenters:

- Norma Pate, Deputy Director
- Rebecca Herzog, Associate Governmental Program Analyst

Enclosures (1): Letter from the Steinberg Institute

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

Back to Agenda

STEINBERG INSTITUTE
1121 L Street, Suite 300
Sacramento CA 95814
T 916.553.4167
steinberginstitute.org

ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

August 21, 2018

Dear Honorable MHSOAC Commissioners,

We are thrilled that you are moving forward with a fellowship program that will open new opportunities for Commission board members and staff to collaborate and communicate with mental health consumers and professionals. The program is a testament to your commitment to highlighting the value of lived experience and state-of-the-art treatment practices as you work to shape and oversee mental health policy in California.

We would like to suggest that these promising new fellowships be named in honor of two distinctive icons who have dedicated their lives to fighting for better services, opportunities, and outcomes for people living with mental illness. We respectfully request the consumer fellowship be named after Sally Zinman; and the practitioner fellowship in honor of Rusty Selix.

Sally has served as a bright and unwavering beacon for the mental health consumer movement. Over more than three decades of activism, she has been a humble but eloquent voice for self-empowerment and self-determination for people living with a brain illness. She has helped elevate and redefine the concept of recovery and planted the seeds for the peer-run programs now flourishing nationwide.

Sally helped launch the nation's first statewide consumer-run organization in the 1970s. Today, as executive director of the California Association of Mental Health Peer-Run Organizations, she remains a potent force, working to shatter stigma, promote a community-based approach to mental wellness, and upholding the civil rights of people living with mental illness.

Rusty was co-author of the Mental Health Services Act, the historic 2004 legislation that has transformed the landscape for mental health treatment in California. For more than three decades, he served as executive director of the California Council of Community Behavioral Health Agencies, working to forge a more effective and responsive mental health delivery system. He has been a strong and persistent voice for destigmatizing brain illness and building a robust continuum of care on par with the system in place for physical illness. Rusty was an early champion of the need to bend the treatment curve toward prevention and intervention, front-end treatment that breaks the cycle of despair that too often accompanies untreated mental

illness. Quite frankly, California's mental health care system would not be where it is without his unrelenting advocacy.

We appreciate your consideration of our request and stand ready to help in any way.

In Partnership,

Maggie Merritt
Executive Director