WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
November 14-15, 2018

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

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

November 14, 2018
9:00 AM – 4:00 PM
AND
November 15, 2018
9:00 AM – 3:00 PM

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

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

Public Notice

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

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

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John Boyd, Psy.D.
Chair

AGENDA

Khatera Aslami-Tamplen
Vice Chair

DAY 1
November 14, 2018

Approximate Times

9:00 AM **Convene and Welcome**
Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Stephanie Smith. Roll call will be taken.

9:05 AM **Announcements**

9:15 AM **Consumer/Family Voice**
Katherine Switz will open the Commission meeting with a story of recovery and resilience.

9:45 AM **Action**
1: Approve October 25, 2018 MHSOAC Meeting Minutes and Reconsider Approval of September 26-27, 2018 Meeting Minutes,

The Commission will consider approval of the meeting minutes from the October 25, 2018 meeting, and will reconsider approval of the September 26-27, 2018 meeting minutes.

- Public Comment
- Vote

9:50 AM **Action**
2: City of Berkeley Innovation Plan (Extension)
Presenter: Karen Klatt, M.Ed., MHSA Coordinator

The Commission will consider approval of $266,134 to support the City of Berkeley Innovation Project extension previously approved in 2016.

- Public Comment
- Vote

10:20 AM **Information**
3: Programs, Providers, and Services Tool
Presenters:

- Rachel Heffley, Associate Governmental Program Analyst
- Brandon McMillen, Associate Governmental Program Analyst

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

- Public Comment

11:00 AM **Information**

4: Executive Director's Report Out

Presenter: Toby Ewing, Executive Director

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

Enclosures:

(1) The Motions Summary from the October 26, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) Commission Meeting Presentation Guidelines; (5) Calendar of Commission activities; (6) Department of Health Care Services Revenue and Expenditure Reports status update.

- Public Comment

11:45 PM **Lunch Break**

1:00 PM **Action**

5: Statewide Early Psychosis Learning Health Care Network Collaborative Innovation Project for San Diego, Solano, Los Angeles, and Orange Counties.

Presenters:

- Tara Niendam, Ph.D. Associate Professor in Psychiatry, University of California, Davis Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics).
- Mark Savill, Ph.D. Assistant Professional Researcher, University of California, San Francisco
- Debbie Innes-Gomberg, Ph.D. Deputy Director, Los Angeles County Department of Mental Health
- Tracy Lacey, LMFT Senior Mental Health Services Manager, MHSA Programs. Solano County Department of Health and Social Services.

The Commission will consider approval of $8,585,747 to support the Statewide Early Psychosis Learning Health Care Network Collaborative Innovation Project for San Diego, Solano, Los Angeles, and Orange Counties.

COUNTY	Total INN Funding Requested
Los Angeles	$4,545,027
Orange	$2,499,120
San Diego	$1,127,389
Solano	$414,211

- Public Comment
- Vote

2:10 PM **Inforrmation**

6: Legislative Priorities

Facilitator: Toby Ewing, Executive Director

The Commission will discuss legislative priorities for the 2019 legislative session.

- Public Comment

2:40 PM **Information**

7: Innovation Incubator Update

Presenter: Toby Ewing, Executive Director

The Commission will be provided with an update on the Innovation Incubator proposal, and will explore future strategies and next steps.

- Public Comment

3:45 PM **General Public Comment**

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

4:00 PM **Recess**

The meeting will be in recess until Day 2, November 15, 2018, at 9:00 AM.

DAY 2
November 15, 2018

Approximate Times

9:00 AM **Welcome**
Chair John Boyd, Psy.D., will provide a brief overview of the strategic planning process for the day.

9:20 AM **Strategic Planning Discussion**
The Commission will hear an update from Susan Brutschy, President of Applied Survey Research on the progress and status of the MHSOAC strategic planning process and will engage in a facilitated strategic planning discussion.

12:00 PM **Lunch**

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

2:45 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

3:00 PM **Adjourn**

AGENDA ITEM 1

Action

November 14, 2018 Commission Meeting

Approve October 25, 2018 MHSOAC Meeting Minutes and Reconsider Approval of September 26-27, 2018 Meeting Minutes

Summary: The Commission will consider approval of the meeting minutes from the October 25, 2018 meeting, and will reconsider approval of the September 26-27, 2018 meeting minutes. 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 (2): (1) October 25, 2018 Meeting Minutes; (2) September 26-27, 2018 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the October 25, 2018 meeting minutes, and approves the September 26-27, 2018 meeting minutes as amended.

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
October 25, 2018

The Marina Inn
68 Monarch Bay Drive
San Leandro, CA 94577

866-817-6550; Code 3190377

Members Participating:

Khatera Aslami-Tamplen, Vice Chair
Reneeta Anthony
Lynne Ashbeck
Senator Jim Beall
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Mayra Alvarez
John Boyd, Psy.D., Chair
Assemblymember Wendy Carrillo
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

Vice Chair Khatera Aslami-Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:02 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Vice Chair Aslami-Tamplen reviewed the meeting protocols.

Youth Participation

The Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Jordan Bouskos introduced herself.

Meeting Calendar

Vice Chair Aslami-Tamplen stated the next Commission meeting and strategic planning session is scheduled for November 14th and 15th at the Riverside Inn in Riverside, California.

ACTION

1: Approve September 26-27, 2018, MHSOAC Meeting Minutes

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

The Commission approves the September 26-27, 2018, Meeting Minutes.

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

The following Commissioners voted "Yes": Commissioners Anthony, Ashbeck, Beall, Brown, Bunch, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Vice Chair Aslami-Tamplen.

INFORMATION

2: Suicide Prevention Project

Vice Chair Aslami-Tamplen stated subject matter experts and stakeholders have been invited to participate in three panels to support the Commission's understanding of opportunities to prevent suicide and improve outcomes for suicide attempt survivors and their loved ones. She stated, since the beginning of the year, the Commission has been working to develop a strategic Statewide Suicide Prevention Plan, as authorized by the Legislature. The Commission has held several meetings this year across the state to explore the challenges and opportunities for preventing suicide in California.

Vice Chair Aslami-Tamplen stated the Commission visited the UCSF Benioff Children's Hospital in Oakland and also participated in a Commission community forum on suicide prevention. She asked Commissioners to share their experiences of yesterday's site visit and community forum.

Commissioner Anthony thanked the UCSF Benioff Children's Hospital, physicians, nurse practitioners, clinicians, peer support staff, and community representatives who were present during the tour to show Commissioners through the facility. She applauded the hospital's efforts in providing seamless services to address needs. She stated what surprised her was a statement made about children between the ages of 8 and 10 who exhibit depression and suicidal ideations, which was concerning. She stated she liked the hospital's model. It would be great to replicate it in other age groups and priority groups.

Commissioner Brown stated it was revealing in terms of the robust menu of services the hospital provides. The dedicated staff were impressive. The site visit also underscored the problem that not only exists at that hospital but throughout the state – the lack of longer-term facilities and beds for young people who are in crisis. Even at this state-of-the-art hospital, Commissioners were told of cases where young children had stayed in the emergency room for 22 days to more than 30 days. It is sad to see that that is still happening. This should be a call to action that the state can and should have a better type of system in place.

Commissioner Madrigal-Weiss stated the need for suicide risk assessments for elementary school students because the schools are seeing more and more children in crisis. The response is to hold children in emergency rooms, which is traumatic in and of itself. She stated the need to do better.

Vice Chair Aslami-Tamplen agreed. She stated the Commission heard the story of an immigrant mother who had to give her child up in order for the child to receive services. The state requires the child to be a ward of the state in order to receive Medi-Cal. She stated stories like this are heartbreaking.

Vice Chair Aslami-Tamplen stated the culture at the Benioff Children's Hospital includes a commitment to serve children regardless of the barriers and a collaboration with the county, local law enforcement, schools, and the whole community in order to serve children and address suicide ideation. She stated the hospital conducts 50,000 mental health visits annually. The hospital implements what they term the gold standard for treatment for suicide prevention, which is Dialectical Behavioral Therapy, and integrates primary care to assess and catch children who are struggling with suicide ideation.

Vice Chair Aslami-Tamplen stated the community forum held yesterday was smooth and well-done. The forum presented an opportunity to share and hear from community members not only in Alameda County but in neighboring counties to learn about what is needed and to discuss how to meet those needs.

Panel 1: Working Upstream to Prevent Suicide

- Lisa Firestone, Ph.D., Director of Research and Education, The Glendon Association, Member of the Santa Barbara County Response Network
- Janet King, MSW, Program Manager of Policy and Advocacy, Native American Health Center

Vice Chair Aslami-Tamplen stated the Commission held its first hearing on suicide prevention at the May Commission meeting. Today, the Commission will hold its second hearing on suicide prevention designed in part to further explore ideas brought forward at the May meeting. She directed the Commissioners' attention to the invitation letters, panelist biographies, and written and slide presentations, which were included in the meeting packet for the three panels of subject matter experts. She introduced the members of Panel 1, who will focus on community-defined and evidence-based methods to prevent the further development of self-harm risk, suicide attempt, and death by suicide.

Janet King

Janet King, MSW, Program Manager of Policy and Advocacy, Native American Health Center, summarized her written responses to the following staff questions, which were included in the meeting packet:

- How the Native American Health Center is delivering programs and services to prevent suicide, restore culture, and build resiliency, particularly for Native American youth
- Opportunities for the state to pursue to support or incentivize the expansion or implementation of community-defined practices which may prevent the development of factors that put individuals at risk for suicidal thoughts and behaviors
- How the state can work with tribes and other Native American communities to prevent suicide and increase community-defined protective factors

Lisa Firestone

Lisa Firestone, Ph.D., Director of Research and Education, The Glendon Association, Member of the Santa Barbara County Response Network, summarized her written responses to the following staff questions, which were included in the meeting packet:

- How The Glendon Association is delivering evidence-based programs and services to prevent suicide and address self-destructive behavior
- Opportunities for the state to pursue to support or incentivize the expansion or implementation of evidence-based practices which may prevent the development of factors that put people at risk for suicidal thoughts and behaviors
- Opportunities for the state to pursue to support and expand coordinated community responses following a suicide, including how the Santa Barbara Response Network assists community members after traumatic events

Commissioner Questions and Discussion

Commissioner Ashbeck stated some of the best work is in unlikely partners. She stated Fresno County has started a gun shop owner outreach around suicide prevention. She stated another example was partnering with the railroad. The Union Pacific Railroad, which operates in 20 states, has the most suicide deaths in the stretch between Kern County and Sacramento. It is a means that is not considered often enough. Unlikely partners are the best hope to try to make a real impact.

Dr. Firestone agreed that unlikely partners are important. She stated the American Association of Suicidology has also been working with gun shop owners. She suggested talking to gun owners about asking to keep individuals' guns for a while. It is different from individuals giving up their gun altogether, but gives a feeling of protecting them when they are in trouble.

Commissioner Bunch asked for additional details on the state-of-the-art advancements mentioned in Dr. Firestone's presentation.

Dr. Firestone stated there are a number of therapies that have been identified that work for suicide prevention that are considered state of the art. She stated individuals who have been in suicidal crisis are more likely to get into suicidal crisis again – it waxes and wanes.

Dr. Firestone stated Safety Planning, which was rolled out by the military, or what Cognitive Behavioral Therapy calls Crisis Response Planning is state of the art. It helps individuals develop and write out the warning signs for them because warning signs are individual. Individuals write down how they know when they are getting into trouble. Once a person is in full suicidal mode, it is difficult to use coping strategies; but, if they can identify when they are starting to get into that mode, they have an opportunity to implement strategies. The person writes down their personalized warning signs, what they can do when they start to notice those warning signs, and who they can talk to in their own social network who can help them.

Dr. Firestone stated, when individuals who have made serious suicide attempts are asked who really helped them save their life, it is usually a friend or family member not a mental health professional. The question is how to help individuals connect to professionals. A caring relationship is important – the quality of the relationship with the mental health professional matters. There are cellphone apps to help individuals connect with mental health professionals.

Dr. Firestone stated Dialectical Behavioral Therapy is a therapy that is state of the art. Another therapy that is state of the art is Cognitive Behavioral Therapy for Suicide, which is different than regular Cognitive Behavioral Therapy. Dr. Aaron Beck, one of the founders of Cognitive Behavioral Therapy, and Dr. Gregory Brown worked to develop a Cognitive Behavioral Therapy treatment for suicidal individuals – even for repeat attempters. A twelve-session intervention has been dramatically effective with military personnel who are multiple attempters.

Dr. Firestone stated the Collaborative Assessment and Management of Suicidality (CAMS), developed by Dr. David Jobes, is another therapy that is state of the art. It is an intervention for suicide prevention that has been found to be incredibly effective. It is an approach that acknowledges that the person who is suicidal is the expert on their situation. The CAMS works collaboratively with the individual, building connections and relationships to address their suicidality. The individual is taught the skills to manage their suicidality.

Dr. Firestone stated the Attempted Suicide Short Intervention Program (ASSIP), developed by Dr. Konrad Michel, is another therapy that is state of the art. ASSIP is a four-session intervention done in the hospital after a suicide attempt. These sessions are incredibly effective. The ASSIP intervention alone saves lives. It is being implemented in many European countries as a standard of care. She asked anyone who is interested in this program to send her an email for further information.

Dr. Firestone stated the newer therapies do not treat the underlining depression or post-traumatic stress, bipolar, anxiety, and substance abuse disorders that may be driving the suicidality, but they take suicide off the table. When suicide is taken off the table, then other treatments can be done to effectively treat the psychiatric disorders. There are state-of-the-art programs that have research behind them. This was not the case fifteen or even ten years ago because there was not enough data. There is now data on approaches that work.

Commissioner Mitchell asked Dr. Firestone if the approaches listed in the response to Commissioner Bunch's question were the five components mentioned in the presentation that most mental health professionals do not use.

Dr. Firestone stated they were.

Commissioner Mitchell asked how to get those five evidenced-based practices out there. Education is the key to improvement. She suggested that it become a requirement in the degree programs.

Dr. Firestone agreed with the importance of teaching at least one of the evidence-based treatments in graduate school. She suggested, if the program focuses more on Cognitive Behavioral Therapy, to teach the Cognitive Behavioral Therapy for Suicide, which is a little different than regular Cognitive Behavioral Therapy. One of the differences is developing a hope kit with the person such as music that makes them happy or movies that make them laugh – building hope is the key to preventing suicide. These evidence-based treatments can be taught to everyone as part of mental health training.

Commissioner Mitchell stated mandating training in at least one evidence-based treatment would be a great start.

Dr. Firestone stated Governor Brown recently signed a bill that requires all applicants for licensure as a psychologist to complete a minimum of six hours of suicide prevention training.

Commissioner Mitchell suggested putting it on the front end by making it a requirement in the schools so everyone gets the same information.

Jordan Bouskos asked if Dialectical Behavioral Therapy skills and emotional wellness trainings that will be part of ninth grade health classes are specifically tailored to high schools or if it can be done earlier.

Dr. Firestone stated the program that was developed was aimed at ninth grade but could be incorporated earlier. She stated skills for managing and regulating emotion are helpful when taught in schools. Decreases in all types of unhealthy behavior are seen when these trainings are given.

Vice Chair Aslami-Tamplen stated the California mental health system is run by the counties. She asked if there are ways that the state can help ensure that counties focus on the suicide prevention needs of Native Americans and other diverse communities.

Ms. King stated the need to ensure that there is contact made with Native American communities, but sometimes counties do not know how. If a good relationship has not been established, and, if the county is depending on the Native American community to reach out to them, the connection may not be made. She gave the example that the Native American communities in Humboldt County did not know they had Prevention and Early Intervention (PEI) funds available through the county. She stated sometimes the Native American communities are very rural and do not come out to where the county offices are, and sometimes counties do not know how to reach out to their Native American communities.

Ms. King also suggested allowing flexibility and avoiding cookie-cutter approaches. Not all PEI programs should be the same. What works for one vulnerable community may not work for others. It is important to allow each community to determine where interventions are most needed.

Ms. King stated there are community-defined practices that sometimes work better than the mainstream evidence-based practices. She stated the California Reducing Disparities Project (CRDP) is currently evaluating 35 community-defined evidence-based practices. She stated the hope that the study will yield evidence that other practices work too, and sometimes work better than mainstream evidence-based practices.

Commissioner Brown asked Ms. King to elaborate on the outlawing of tribal ceremonies that are now being put back into practice.

Ms. King stated many historical federal and state policies stated these ceremonies could no longer be practiced and, if caught practicing them, individuals could be jailed or killed. Many ceremonies had to go underground. Also, there were federal policies that took children from their families and put them in boarding schools, which stopped the transmission of culture to the next generation.

Ms. King stated spiritual and secular cultures are not separated in the Native American community; it is all one culture. That might be one of the disconnects when federal policy was being made. What was outlawed when culture was outlawed was everything that kept the community well. She stated one of the ceremonies that was outlawed was the grieving ceremony. There was a lot of grief and loss with the genocide and assimilation policies. The grieving ceremony brought closure to grief and loss but was then outlawed. It is important to restore culture as much as possible.

Commissioner Brown stated Ms. King's examples were historical. He stated there is nothing today in federal law to keep Native American communities from practicing the ceremonies. He stated there is a resurgence of Native American culture in his county.

Ms. King stated there is a family in Oakland who has offered their land for sweat lodge ceremonies. There have been many meetings with the Oakland City Council to discuss this because there are individuals who are against the practice being done in their neighborhood. Although it is not illegal, it is still often difficult to practice these traditional healing practices.

Commissioner Mitchell asked if it is a zoning issue.

Ms. King stated neighbors have complained that they do not like the practice because it disturbs their lifestyle.

Commissioner Beall asked if there is a need to clarify the policies and laws regarding tribal healing ceremonies.

Ms. King stated there are laws that protect Native American families, such as the American Indian Religious Freedom Act of 1978 and the Indian Child Welfare Act of 1978. She stated it would help Native American families if the laws were enforced, especially for tribes that do not have federal or state recognition. There is a question as to whether the Indian Child Welfare Act applies to them.

Ms. King stated many city, county, and state governments are unaware of these laws of sovereignty for the tribes that have federal or state recognition. She stated people do not understand what it means to have a sovereign nation living in their state and it brings up many issues. She stated the need for education about what it means and how it changes the relationship from a government-to-government relationship for the tribes that have state or federal recognition.

Ms. King stated enforcing the law would help, especially with the Indian Child Welfare Act to keep Native American families together. She stated this is always challenged. Even though it is a federal law, not everyone implements it. The steps to keep a child engaged with their culture are not always taken. She stated her experience with the counties is that they feel bothered that there is this law that they have to comply with.

Ms. King stated there are laws about young children needing to be placed within a certain amount of time, such as six months, but six months is not a lot of time for a family to stabilize itself in order to have their children returned to them. Some of the general laws that apply to all children need to be reexamined to see if they are presenting barriers for Native American families to regain their children. Laws are set up to protect people but sometimes the law continues to separate them.

Commissioner Beall stated it sounds like, if there was someone in the Department of Health Care Services (DHCS) who could focus on health and social services for Native American communities in California and who could develop guidance to the counties, it would help with the confusion in terms of the child welfare laws and health care practices that benefit Native Americans.

Commissioner Beall stated the Native American health care center in his county has told him that they cannot get Medi-Cal reimbursements for certain types of health care programs that they want to do with children such as a youth gathering with tribal elders. He stated this program is effective in his area with teens but they cannot get funding because the Medi-Cal reimbursement system is not flexible enough to help them.

Vice Chair Aslami-Tamplen stated the importance of continuing the conversation on these issues.

Ms. King agreed and stated these conversations are complex. Just because these issues are strange to people who are not used to hearing about them does not mean that they are not true.

Commissioner Madrigal-Weiss agreed about practices being used in the dominant culture. She stated her organization is currently doing work in the schools on restorative practices. The core principle there began with the Native American cultures. She stated the need to get realistic about that, especially when working with communities that want to bring in restorative practices to the Native American communities. She stated the importance of continuing to honor traditions and where they came from.

Commissioner Madrigal-Weiss stated her organization is constantly looking for new programming around social-emotional learning. She referred to the Gathering of Native Americans (GONA) program and stated the values, plans, and mastery highlighted with youth to find their gifts that they can share with others, the interdependence, cooperation, and giving back are things her organization is trying to get into schools and youth.

Ms. King stated she is trying to make the GONA program an evidence-based practice. It was not a priority to do it earlier because it was more important to implement the practice. She stated the need to evaluate the GONA program now.

Panel 2: Intervention Through Crisis Care and the Health Care System

- David Camplin, LMFT, Director of Behavioral Health, San Bernardino County Service Area, Kaiser Permanente
- David Covington, LPC, MBA, CEO and President of RI International
- Katherine Jones, RN, MS, MSN, Director, Adult/Older Adult System of Care, Alameda County Behavioral Health Care Services

Vice Chair Aslami-Tamplen introduced the members of Panel 2, who will focus on opportunities in crisis care, health care, and behavioral health care systems to prevent suicide.

<u>David Covington</u>

David Covington, LPC, MBA, CEO and President of Recovery Innovations (RI) International, showed a video titled “It’s Been a Bad Day.” He walked through a PowerPoint presentation providing responses to the following staff questions, which were included in the meeting packet:

- How the Crisis Now Model and the Zero Suicide Initiative efforts have the potential to prevent suicide and suicide attempt
- How the state can reduce challenges and barriers to implementing the Crisis Now Model and the Zero Suicide Initiative, including capacity, training, and coordination challenges
- Short-term and long-term opportunities for the state to pursue to strengthen crisis care, health care, and behavioral health care delivery systems using approaches identified in the Crisis Now Model and the Zero Suicide Initiative and incentivize such approaches

<u>Katherine Jones</u>

Katherine Jones, RN, MS, MSN, Director, Adult/Older Adult System of Care, Alameda County Behavioral Health Care Services, provided her responses to the following staff questions, which were included in the meeting packet:

- How Alameda County Behavioral Health Care Services delivers a crisis care continuum, including crisis hotline, mobile crisis, and crisis residential
- How the state can support local efforts to strengthen crisis services to improve coordination and timely connection of people to services, reducing outcomes such as hospitalization, suicide, and suicide attempt
- How Alameda County plans to implement the Zero Suicide Initiative, including challenges and barriers to implementation

David Camplin

David Camplin, LMFT, Director of Behavioral Health, San Bernardino County Service Area, Kaiser Permanente, walked through a PowerPoint presentation providing responses to the following staff questions, which were included in the meeting packet:

- How Kaiser Permanente is implementing the Zero Suicide Initiative, including challenges to implementation
- How the state can reduce challenges and barriers to implementing approaches to prevent suicide by people utilizing services in health and behavioral health care systems, such as those proposed by the Zero Suicide Initiative, including capacity, training, and coordination challenges
- Opportunities for the state to pursue to incentivize suicide prevention strategies, including collaborative care, for private health and behavioral health care systems

Commissioner Questions and Discussion

Commissioner Anthony asked about the addition of peers within the Kaiser system and if Kaiser plans to incorporate persons with lived experience in the treatment group in the future.

Mr. Camplin stated Kaiser has peer panels that are brought together to work on initiatives and provide input. Many managers are piloting small projects to try to build a peer support system but there is nothing formal at this point.

Commissioner Anthony stated she looks forward to when the hospital system will be in the forefront of incorporating peers.

Commissioner Danovitch asked Mr. Covington about the most important barrier or barriers faced in implementing the Crisis Now Model and the Zero Suicide Initiative and how the Commission can be most impactful or helpful in overcoming that barrier and moving this forward.

Mr. Covington stated there was a ten-year period where innovations in crisis would occur in individual cities or counties but those programs were largely disconnected from larger systems and were not scaled at any level. Over the last 12 years, full states and large regions are beginning to take these programs on and they are doing it for a variety of reasons such as cost efficiency, public safety, and lawsuits.

Mr. Covington stated the most attention given to those so far has been around the issue of cost. Approximately five years ago, California invested $150 million in those three services but that has seemed to have stalled at some point. He suggested picking up those efforts and processes already put in place and drive that forward along the lines that Colorado, Georgia, and Arizona have.

Commissioner Brown stated he agreed with many things shown in the presentation but he stated his concern that it oversimplifies some of the things such as the comment that the police are the untrained mental health workforce. He stated he takes issue with that because many law enforcement agencies are doing a lot to train employees in the Crisis Intervention Team (CIT) Program, de-escalation, and a variety of other issues. He stated the concept that having a mobile crisis team that responds but does not include law enforcement is perhaps flawed because the reality is that many calls received are still going to require law enforcement response. It is important to have an integrated response when that happens.

Commissioner Brown stated the study in Mariposa referred to in the presentation cited that it saved the equivalent of 37 full time police officers. He stated what happens, unfortunately, is a lot of times city councils and boards of supervisors will look at something like that and say they can implement this program and cut the police department by 37 positions to pay for it. The reality is that an equal amount cannot be cut – there are fixed costs, minimum staffing levels, and situations in many law enforcement agencies where staffing levels are significantly lower than out-of-state staffing levels such as in Arizona, Texas, and Georgia. Those numbers have been cut for so many years that they are to the point where certain things that law enforcement should still be doing in the field have been dropped long ago.

Commissioner Brown suggested guarding against an oversimplification of showing something like this. The caveat should be that there is not a one size fits all for communities. In fact, it would be almost impossible to try to duplicate this model in most of California's medium- and small-sized counties.

Commissioner Brown stated he recognized that Mr. Covington is a vendor and has a financial interest in this model. He asked if there has been an attempt on the national level to try to encapsulate this idea that is coming from sources that are not in the business.

Mr. Covington stated the crisisnow.com website is not a website of RI International but is a website of the National Association of State Mental Health Program Directors (NASMHPD). He stated Brian Hepburn, M.D., the Executive Director of the NASMHPD, believes that this model is the single most transformative opportunity in mental health today. The partners on that are the National Council for Behavior Health, which is the trade association of the 3,000 community mental health centers, the National Suicide Prevention Lifeline, which is the network of crisis centers nationally, the National Alliance on Mental Illness (NAMI), and the National Action Alliance for Suicide Prevention, which catalyzed and brought this model forward. The partners in developing Crisis Now were law enforcement leaders.

Mr. Covington stated the issue for RI International is not that 37 police officers should be cut, but rather that they are being asked to fulfil tasks such as transportation when their job is to provide public safety. He stated what has been seen in both metropolitan and rural areas is that crisis services are being delivered in two-person teams. The reason the two-person team is important is so that they can go to an apartment or to the street. They have a system of triaging out the level of dangerousness in each situation. If there is a concern about a history of violence or a weapon, the two-person team will want law enforcement on the scene either on a Level 1 to clear the scene or on a Level 2 to be there and available. He stated the vast majority of the thousands of calls received per month do not involve law enforcement.

Mr. Covington stated his experience is that law enforcement is the entity that is driving this initiative more than the hospitals or behavioral health providers. He stated law enforcement wants to be engaged; they want to be a partner, but they do not want to do the job of the mental health system providers because of the challenges it creates.

Panel 3: Building Infrastructure, Leadership, and Sustainability

- Colleen Carr, MPH, Director of the National Action Alliance for Suicide Prevention
- Peter Manzo, President and CEO, United Ways of California

Vice Chair Aslami-Tamplen introduced the members of Panel 3, who will focus on opportunities for strengthening statewide suicide prevention leadership, including forming partnerships with private sector partners.

Colleen Carr

Colleen Carr, MPH, Director of the National Action Alliance for Suicide Prevention, summarized her written responses to the following staff questions, which were included in the meeting packet:

- How the National Action Alliance for Suicide Prevention utilizes a private-public partnership to advance the national suicide prevention strategy
- Opportunities for the state to pursue private-public partnerships as a possible method to advance its own suicide prevention strategy, including examples from other states
- How the state could support and incentivize expansion of suicide prevention efforts in private industry settings, including the workplace, private health care, and private senior living communities, such as nursing homes and assisted living facilities

Peter Manzo

Peter Manzo, President and CEO, United Ways of California, summarized his written responses and walked through a PowerPoint presentation providing further resposnes to the following staff questions, which were included in the meeting packet:

- How United Ways of California and its network of affiliates are delivering services that prevent suicide and promote protective factors
- How programs and services delivered by nonprofits, such as United Ways, can be integrated with other health care and behavioral health care systems to prevent the development of factors that put people at risk for suicidal thoughts and behaviors
- Opportunities for the state to pursue private-public partnerships as a possible method to advance its suicide prevention strategy, including the role of nonprofits in such a partnership

Commissioner Questions and Discussion

Commissioner Ashbeck stated the single biggest thing to make it easier for individuals to get care is if 211s were equally good across the state. The 211 in Fresno County is not reliable and tends to be overlooked. She suggested, while thinking about innovation strategies statewide, to think of ways to strengthen the 211 capacity so that it is equal and can be built into networks to help accelerate access to help.

Commissioner Ashbeck stated her biggest worry is the Substance Abuse and Mental Health Services Administration (SAMHSA) assessment is not enough – that traction is not being made. She stated there are national strategies for suicide prevention, the Commission is working on a statewide strategy for suicide prevention, and there are local strategies for suicide prevention. She stated she does not need three strategies because they are not making any traction. She asked Ms. Carr how she sees those three things intersecting.

Ms. Carr stated one of the questions asked in SAMHSA's National Strategy for Suicide Prevention Implementation Assessment Report was whether states have adapted their strategy now that the national strategy has been revised. She stated one of the things the National Action Alliance for Suicide Prevention saw was that the vast majority of states have updated their strategy based on the revised national strategy. The national strategy is big-picture enough that it can be tailored. The state and local strategies can be refined more to what is known about their data and populations. The national strategy has to use large datasets but risk factors are unique to communities and can be tailored that way.

Ms. Carr stated the National Violent Death Reporting System will now be in all 50 states and there are states that have done mapping to the county level to learn who is at greater risk in their counties. She stated the data shows that the demographics are a much older population than a lot of the interventions are targeted to because of various funding streams. She stated it needs to be tailored to the next level – to what is specific to each population based on what is known to be most effective.

Commissioner Ashbeck stated the importance of putting the three strategies together so there are not three lanes of work.

Ms. Carr agreed and added that they should inform each other.

Jordan Bouskos stated she loved the 211 concept. She stated being offered many different resources on who to call during a crisis can be overwhelming. Having one specific contact that is available at all times is phenomenal. She asked if there is a comparable text version.

Mr. Manzo stated many of the 211 providers are using text messaging now. Increasingly, individuals are seeking help through web searches and text conversations, with the result that calls are leveling off or flattening. The future is text and mobile communication. He stated the caveat that high quality must be attained everywhere. There are two hundred and forty-six 211s across the country. He stated United Ways of California is trying to work together as a network in California and in other states.

Public Comment on All Panels

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), was sorry to have missed yesterday's site visit and community forum on suicide prevention, which the speaker heard was a fabulous day. The speaker missed yesterday's events because the speaker attended Alameda County's Annual Cultural Competence Summit, which was great.

Stacie Hiramoto thanked staff and the Commission for today's presenters who were very good. Janet King's presentation was like a recap of what was discussed at yesterday's conference during the Native American plenary. The members of the plenary spoke about historical trauma being real and not just a passing fad and about the outlawed practices. The speaker stated the laws may have been from long ago but the effects of those laws and the practices that still continue today linger in the Native American culture.

Stacie Hiramoto stated there is new and exciting scientific research on epigenetics that talks about trauma and what happens to individuals – that their genetic makeup changes and they pass on these things to children and grandchildren.

Rory O'Brien, LGBTQ Program Coordinator, Mental Health America of Northern California (NorCal MHA), Project Coordinator, Out 4 Mental Health, thanked Janet King for providing a historical background and recognizing that today's meeting is on stolen Ohlone land. The speaker stated histories of de jour illegalization of indigenous customs and cultures reverberate today in efforts such as the Not-in-My-Backyard (NIMBY) effort that works to invisibilize Native American people and customs, and in Native American movements to announce and maintain their rights to ancestral lands, which are sacred and are often tied to specific customs and rituals.

Rory O'Brien featured MHSOAC-funded work on suicide prevention that is already being implemented today through Out 4 Mental Health. In the past year, 121 parents, professionals, and educators were trained in Rapid Suicidality Assessment specific to LGBTQ youth in Woodland, West Sacramento, Oroville, San Luis Obispo, and San Bernardino.

Rory O'Brien stated this work will continue through Out 4 Mental Health in the coming year. A statewide research program will begin in August of 2019 on the mental health of LGBTQ youth, which will include assessment on suicidality disproportional risk for LGBTQ youth. Given the ongoing training with parents, professionals, and community members on LGBTQ youth risk in particular, the speaker stated the hope that the Commission will continue to engage Out 4 Mental Health in the development of the Statewide Suicide Prevention Plan and look forward to that research to inform the Commission's work.

Poshi Walker, LGBTQ Program Director, NorCal MHA, Co-Director, Out 4 Mental Health, dittoed Rory O'Brien's comments. The speaker worked with Janet King on the CRDP for five years and appreciated Janet King's presentation.

Poshi Walker spoke about the evidence-based practices discussed today. The speaker stated the need to ensure, when hearing about evidence-based practices, that that evidence was also gathered on sexual orientation and gender identity because what works for straight and cisgender individuals may not work with LGBTQ individuals.

Poshi Walker stated research was previously presented to the Commission in May by Caitlyn Ryan, Ph.D., Director, Family Acceptance Project, San Francisco State University, that family acceptance is a key component to preventing suicide for LGBTQ youth and young adults. Further research has shown that parental rejection is the most important factor, even greater than school environment, when it comes to suicidal ideation for LGBTQ youth. The speaker stated suicide prevention methods for LGBTQ youth must include work with parents, families, religious leaders, and teachers who may be contributing to the rejecting messages that can lead to suicide ideation.

Poshi Walker stated, in order for some if not all of the practices presented today to prevent suicide in LGBTQ populations, the person, especially the youth, cannot be consistently told that they are disgusting, sinful, and unworthy of acceptance or that who they are is not real because their gender does not match the sex they were assigned at birth; therefore, suicide prevention must include community education in order to create the needed cultural shift toward acceptance and affirmation of those on the LGBTQ spectrum.

Poshi Walker stated Out 4 Mental Health is doing this work with the support of MHSOAC funding on both the state and local level, and therefore Out 4 Mental Health hopes to be strongly engaged in the development of the Statewide Suicide Prevention Plan and in future MHSOAC suicide prevention work.

Anara Guard, a consultant on suicide prevention in California, has consulted for the Know the Signs Campaign and a number of other initiatives. The speaker stated the panels were wonderful. Anara Guard highlighted two California resources to ensure that everyone knows about them:

- The My3 mobile safety planning app, maintained by the National Suicide Prevention Lifeline, was developed in California with county funding through the California Mental Health Services Authority. This app is now being used across the county. It takes all the features of a safety plan and puts them on a cellphone. It is not only more mobile, it is more private than having that information on a piece of paper, it will not go through the laundry like paper, allows individuals to email customized safety plan information to anyone they choose, and makes it easy for individuals to contact their personal network.
- The Gun Violence Restraining Order law allows family, law enforcement, and certain other individuals to petition a court so that firearms can be temporarily removed by order of a judge from someone who has been shown to threaten violence against themselves

or others. Reducing access to lethal means has been shown to be effective against suicide. At least 13 other states have passed or are in the process of passing laws based on California's model. The Gun Violence Restraining Order law is being evaluated by the Johns Hopkins University. Law enforcement has been supportive of this law. Firearms that are temporarily removed can be returned after a period of time when the individual is shown to no longer be a threat or a danger. Speakforsafety.org is a website with all the information needed including the roles of mental health providers and others. Not enough counties know about this law. It is important to spread the word about it.

Steve Leoni, consumer and advocate, stated, if the Commission uses the building blocks shared today and puts them together using common elements and synergy, the Statewide Suicide Prevention Plan will be one of the best reports ever done on this subject. Despite the praises given to the Benioff Children's Hospital during the site visit report-out earlier today, it was mentioned that there were still children who spend 20 days or more in emergency rooms waiting to get treatment. The speaker suggested comparing that to the Crisis Now model, but not just looking at it as children's services versus crisis services, but to put the pieces together.

Steve Leoni stated at the end of last month's Commission meeting Jon Sherin, Director, Los Angeles County Department of Mental Health, came in and was very enthusiastic about the county's hosting visiting leaders in the mental health field from around the world. The visiting leaders shared about the Trieste model. The speaker stated the Trieste model looks very like the Crisis Now model and is worth looking into.

Steve Leoni stated Dr. Firestone mentioned distress levels rising above the coping mechanisms and that 50 percent of suicides are not connected with mental illness. There is a mechanism in the general population that is also in individuals with mental illness. Those mechanisms cannot be canceled out because an individual has a mental illness, but it is an issue on both sides.

Steve Leoni stated Mr. Camplin mentioned uninterrupted care transitions as part of the Kaiser model. The speaker stated an individual being discharged from urgent care is guaranteed an appointment within several days. The speaker asked how that compares to uninterrupted care transitions, which is also a value of the Mental Health Services Act (MHSA).

Steve Leoni stated Marsha Linehan, Ph.D., the psychiatrist who designed Dialectical Behavioral Therapy, is a person with lived experience and used that experience in designing that very useful model.

Smitha Gundavajhala, Youth Leadership Institute, stated her journey into mental health advocacy began with suicide prevention with one of her friends. The speaker noted themes from today's conversation:

- All determinants of mental health should be seen as opportunities for suicide prevention and intervention. Oftentimes, mental health and suicide prevention conversations are not linked. It is not thought of as a gradual development or a continuum of suicidal ideation.
- Thinking about how to streamline the process of community partnership from the last panel is important both in suicide prevention strategies and in other areas of mental health work. Public mental health systems lean on nonprofits and community-based organizations to serve the communities in which they are already well-situated.
- Community organizations not only provide streamlined systems of care, but also are pipelines of community feedback in advocacy, feeding input back to the state on their needs and on the effectiveness of the services that have been rendered, especially thinking about funding structures that can support and prioritize collaboration. There is a

fear of double-dipping that informs contracting in a way that not only discourages collaboration, but may also unintentionally incentivize duplication.

- There is no one-size-fits-all solution that meets the unique needs of every community. There is a need for a community needs-based contracting and evaluation process as a best-practice priority for suicide prevention and other critical work to move forward.

Smitha Gundavajhala highlighted the historical trauma mentioned by Janet King. The speaker stated there are many different determinants of mental health; a lack of cultural memory is very real for many persons of color.

Vice Chair Aslami-Tamplen recognized Jay Moller, a pioneer of the consumer movement across the nation. She stated Jay Moller is the founder of many programs that are consumer led.

LUNCH BREAK

ACTION

3: Elect Chair and Vice Chair for 2019

Facilitator: Filomena Yeroshek, MHSOAC Chief Counsel

Ms. Yeroshek briefly outlined the election process and asked for nominations for chair of the MHSOAC for 2019. Commissioner Ashbeck nominated current Vice Chair Aslami-Tamplen and Commissioner Bunch seconded the nomination. There were no other nominations.

Vice Chair Aslami-Tamplen stated that it's been an honor and a wonderful journey serving on the Commission and on the Client and Family Leadership Committee before that. It would be a huge honor to serve as chair along with Commissioners whom she deeply admires, staff that she respects and stakeholders that she is fully committed to represent and uphold a process that is inclusive of all.

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

The Commission elects Vice Chair Khatera Aslami-Tamplen as chair of the Mental Health Services Oversight and Accountability Commission for 2019.

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

The following Commissioners voted "Yes": Commissioners Anthony, Ashbeck, Beall, Brown, Bunch, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Vice Chair Aslami-Tamplen.

Ms. Yeroshek asked for nominations for Vice Chair of the MHSOAC for 2019. Commissioner Danovitch nominated Commissioner Ashbeck and Vice Chair Aslami-Tamplen seconded the nomination. There were no other nominations.

Commissioner Ashbeck stated that she is honored to serve those who count on the mental health services across the state and to support those who deliver those very important services. She too looks forward to working with Commissioners to do this important work.

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

The Commission elects Commissioner Lynne Ashbeck as Vice Chair of the Mental Health Services Oversight and Accountability Commission for 2019.

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

The following Commissioners voted “Yes”: Commissioners Anthony, Ashbeck, Beall, Brown, Bunch, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Vice Chair Aslami-Tamplen.

Public Comment

Tracy Hazelton, MHSA Division Director, Alameda County Behavioral Health, presented Vice Chair Aslami-Tamplen with a plant from Alameda County Behavioral Health Care Services in honor of her work for Alameda County and in the MHSOAC.

Sally Zinman and Rusty Selix MHSOAC Fellowship Programs

Vice Chair Aslami-Tamplen stated the Commission wants to recognize both Sally Zinman and Rusty Selix and thank them both for the work that they have done, for their lifetime of advocacy and dedication to mental health.

Vice Chair Aslami-Tamplen and Commissioner Beall presented resolutions from the California State Senate to Sally Zinman commemorating the naming of the MHSOAC Fellowship Programs in her honor. Commissioners and members of the public described how Sally Zinman had inspired and mentored them.

Rusty Selix, who has been ill, was unable to attend the meeting. Commissioners and members of the public also honored Rusty Selix with fond memories about his positive impact on their lives.

ACTION

4: <u>Alameda County Innovation Plans (3)</u>

Presenters for Introducing Neuroplasticity to Mental Health Services for Children:

- Catherine Franck, LCSW, Behavioral Health Clinical Manager for Child and Young Adult System of Care
- Sindy Wilkinson, MEd, LMFT, Behavioral Health Clinician for Child and Young Adult System of Care

Presenters for the Community Assessment and Transport Team (CATT):

- Stephanie Lewis, MS, LMFT, Interim Crisis Services Division Director
- Karl A. Sporer, M.D., Emergency Medical Services Medical Director
- Melissa Vallas, M.D., Alameda County Care Connect Crisis Liaison/ Lead Psychiatrist for Children's System of Care

Presenters for the Emotional Emancipation Circles for Young Adults:

- Lisa Carlisle, MA, Med, Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care
- Shannon Singleton-Banks, MPH, Senior Program Specialist for Alameda County's Public Health Department

Vice Chair Aslami-Tamplen asked Commissioner Gordon to facilitate this agenda item, recused herself from the discussion and decision-making with regard to this agenda item, and left the room pursuant to Commission policy.

Commissioner Gordon introduced the presenters for the Alameda County Behavioral Health Care Services Innovation Plans.

Ms. Hazelton stated Jeff Rackmil, Director, Child and Young Adult System of Care, Alameda County Behavioral Health, was unable to be in attendance today and Lisa Carlisle, Medi-Cal Specialty Mental Health Coordinator, Child and Young Adult System of Care, will present in his place.

Ms. Hazelton stated, like many counties, Alameda County has been working on their Innovation projects for one year. The three Innovation projects that will be presented today come from local stakeholder input and are connected to statewide strategies and priorities such as Senate Bills 82 and 1004 and the CRDP.

Introducing Neuroplasticity to Mental Health Services for Children

Catherine Franck, LCSW, Behavioral Health Clinical Manager for Child and Young Adult System of Care, provided an overview, with a slide presentation, of the presenting need for the proposed Innovation project.

Sindy Wilkinson, MEd, LMFT, Behavioral Health Clinician for Child and Young Adult System of Care, continued the slide presentation and discussed the innovative components and evaluation of the proposed Innovation project.

Lisa Carlisle, MA, Med, Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care, continued the slide presentation and discussed the budget and sustainability of the proposed Innovation project.

Commissioner Questions

Commissioner Anthony asked for a description of the integration of the engagement and support that will be provided by the Child Welfare Division within the county for this program.

Ms. Carlisle stated Alameda County works with a large population of young people, some of whom are involved in the child welfare system. Much of the work is partnered with the social services agency in serving these children and young people. These young people are in school and are able to access the services with the Holistic Approach to Neuro-Developmental and Learning Efficiency (HANDLE) program. With the teaching and the training of the faculty and staff, there is always a lot of communication and coordination that goes along with providing supports and services to these young people, whether it is working with the case worker or juvenile justice.

Ms. Carlisle stated, in terms of the direct input that social services has with the HANDLE model, that is not part of the schematic, but there is room for further cooperative learning experiences to be had with those divisions on behalf of those young people and their families.

Commissioner Madrigal-Weiss stated that per the presentation the goal is to reach 200 students and asked what is the total need.

Ms. Hazelton stated page 111 of the Innovation plan outlines how the county got to the goal of 70 students per year. She stated 55 percent of students have been identified to have experienced some form of trauma.

Commissioner Madrigal-Weiss asked if the children who will be referred for the proposed project already have individualized education programs (IEPs) in place or if anyone can make a referral.

Ms. Wilkinson stated it is both. Some students will already have IEPs in place and some will be referred by parents, teachers, or school counselors.

Commissioner Madrigal-Weiss asked how missed academics will be accommodated if there was not an IEP.

Ms. Wilkinson stated the children are struggling emotionally and probably academically as well. Their focus is more on survival than on academics. Class time is not well spent. Even though students will be pulled out of classes, it will help to reduce that fight-or-flight response so they will increase their readiness to learn when they are back in the classroom.

Commissioner Bunch stated the student should already be identified if they are struggling that much. She asked how to explain to the general education teacher that a student does not have an IEP but the school wants to remove them from class to introduce this program.

Ms. Wilkinson stated the county will be training teachers so they will understand the issue from a different perspective and have a better understanding of who this will help. That allows them to look at it differently rather than that their students are being pulled out of the classroom.

Commissioner Bunch asked how the children will be identified in terms of referral.

Ms. Carlisle stated HANDLE has been identified as one of the school models. Behavioral Health Care will partner with the school districts to develop Coordination of Service Teams (COST). Students are referred to those COSTs for a variety of needs, whether academic or mental health. It is not inventing a new referral process; it is including additional services in the current process.

Commissioner Bunch asked about cultural competency training that the county will do.

Ms. Carlisle stated it is not a secret that certain populations are overrepresented in certain services. HANDLE will help identify the needs of young people as opposed to how the adults are receiving those behaviors. Some of the work that HANDLE will do is to educate the educators and parents on those things that are affecting young people so that, when looking at young people in the classroom settings or school grounds, the teacher will not focus on the way a certain behavior makes them feel. Cultural competency is part of what is done in behavioral health care. There is a variety of different types of training on trauma and cultural responsiveness that is offered through the county.

Commissioner Bunch suggested that cultural competency training be mandatory instead of being offered and available.

Ms. Carlisle stated there is room for that consideration.

Commissioner Bunch asked about the HANDLE assessment.

Ms. Wilkinson stated there are two levels of assessment. There is a screening, which is a broad stroke to learn of potential neurodevelopmental issues. These issues would then be addressed through specific copyrighted interventions. The second level of assessment dives deeper into what is going on in those neurodevelopmental systems to get a clear pattern of how each system is gathering information and transferring it to the brain and how the brain is integrating that information so that more efficient processes can be made.

Commissioner Mitchell asked how a student would look prior to and after changing their brain plasticity.

Ms. Wilkinson stated the plasticity part is that the brain can always change. There can be a multitude of behaviors or learning issues that are irregularities in how the brain is processing the information it is getting from the world. The HANDLE assessment figures out what those irregularities are. The interventions gently and carefully strengthen those systems while keeping the internal stress levels down so the body can process what is going on in the world much better.

In response to a question from Commissioner Mitchell Ms. Wilkinson stated that the training, expertise, and consistency to improve a child's functions will always be there.

Commissioner Ashbeck asked if the $2 million pilot is for 200 children.

Ms. Wilkinson stated the pilot will serve approximately 200 children and will provide the training for many individuals in the school districts and the county to give them a different understanding of behavior and mental health.

In response to Commissioner Ashbeck's question about the history of HANDLE and if it is used with children, Ms. Wilkinson stated HANDLE has been in existence for over 30 years. It was created by a woman who needed it herself. Ms. Wilkinson has been doing this work privately for approximately 17 years and has worked with hundreds of clients from the ages of 1 through 75. HANDLE works with individuals of all ages. The county is choosing to work with children.

Ms. Wilkinson stated, although there is anecdotal evidence, the only research on HANDLE is a traumatic brain injury study that was highly successful. She stated there is not much scientific research, but there is related research that indicates that neurodevelopment affects behavior and mental health. The proposed project is innovative because those components are being put together.

Community Assessment and Transport Team (CATT)

Melissa Vallas, M.D., Alameda County Care Connect Crisis Liaison/Lead Psychiatrist for Children's System of Care, provided an overview, with a slide presentation, of the presenting need for the proposed Innovation project.

Karl A. Sporer, M.D., Emergency Medical Services Medical Director, continued the slide presentation and introduced the proposed Innovation project.

Stephanie Lewis, MS, LMFT, Interim Crisis Services Division Director, continued the slide presentation and discussed the innovative components and evaluation of the proposed Innovation project.

Dr. Vallas continued the slide presentation and discussed the budget for the proposed Innovation project.

Ms. Lewis finished the slide presentation by discussing the sustainability of the proposed project.

Commissioner Questions

Commissioner Anthony asked how the county plans to engage individuals who do not want to participate in the 5150 process.

Ms. Lewis stated part of the unique staffing model is the inclusion of a behavioral health clinician and an emergency medical technician (EMT). Sometimes the behavioral health clinician develops a rapport with an individual and sometimes it is a medical professional. There is more to offer with the unique staffing model and the ability to transport individuals to a wide variety of services.

Commissioner Anthony asked if there is a certain approach that will be used to engage individuals who do not want to participate in the 5150 process.

Ms. Lewis stated the first thing the county does is introduce themselves and explain what the service is. The team will be doing outreach and engagement in non-crisis times in areas that the county knows these individuals are spending their time, will identify themselves as a team trying to meet individuals where they are, and will involve the individuals in the decision-making process instead of pushing a particular model.

Commissioner Ashbeck asked if the EMTs will receive any special behavioral health training to be part of this two-person team.

Ms. Lewis stated they will.

In response to a question from Commissioner Ashbeck Ms. Lewis stated that the clinician will be designated to write 5150 holds.

Commissioner Ashbeck asked if the county's emergency medical service (EMS) providers currently transport 5150s to alternative destinations besides an emergency department, such as a sobering center or crisis center.

Dr. Sporer stated they are currently all paramedics and must transport to a licensed emergency department. He stated approximately 55 percent of the transports go to an emergency department and approximately 45 percent go directly to John George Psychiatric Emergency Service.

Commissioner Ashbeck asked how the proposed project will achieve the 25 percent reduction in hospital emergency department transports when the county currently does not have an alternate destination policy.

Dr. Sporer stated paramedics cannot transport to sobering centers because sobering centers are not licensed emergency departments; however, EMTs can.

Commissioner Ashbeck asked if part of the funding will create the infrastructure for the Community Care Plan.

Dr. Sporer stated ReddiNet is already functioning now. The proposed project adds a component but the psychiatric services have already been developed in Ventura County. ReddiNet lists bed availability; the average paramedic will not see the bed availability for psychiatric beds because it does not concern their decision-making. Only the health care worker will see that.

Dr. Sporer stated the community health care record is a large portion of the Alameda County Care Connect/Whole Person Care Project. An $8 million Request for Proposal (RFP) was recently awarded to develop this for the 16,000 individuals who need this community health record plan. The proposed Innovation project will tap into that plan to have password-protected access to this information.

Ms. Lewis stated the team will have access to the community health record that is being developed for the entire county of Alameda for patients who are Care Connect eligible.

In response to a question from Commissioner Ashbeck Ms. Lewis stated the Community Care Plan is scheduled to be launched around April of 2019. A prototype community health record is currently being modeled; the team is set to utilize that as well.

Commissioner Ashbeck asked about the SB 82 triage funding received by Alameda County and how the three streams of funding – Whole Person Care, SB 82 triage, and Measure A – will go together.

Dr. Sporer stated Measure A is the public safety tax. The funds will be used to purchase the vehicles and to hire a senior program specialist. Interviews will begin soon.

Dr. Vallas stated the Whole Person Care funding is not included in today's proposal but the products will be used within the funding.

Commissioner Bunch asked if the county will see all bed space availability not just psychiatric beds with the ReddiNet System.

Dr. Sporer stated the ReddiNet System is a web-based system that shows the hospitals that are open, that have equipment down, or other difficulties. It also can be used to alert hospitals when a number of patients are being transported in. There will be an added component for bed availability for crisis residential or multiple other locations that have beds. The team determines the needs of an individual, goes on ReddiNet to see what is available, and delivers the patient there.

Commissioner Danovitch stated the mechanisms identified to sustain the proposed project appear to be currently available. He asked what will change in order to close gaps and fund the project on an ongoing basis.

Ms. Hazelton stated the county is looking to test this model with Innovation funding. The funding is potentially available now but the county would like to test if having an EMT

with the technology software connected with the clinician works. Other models have used one paramedic or a two-clinician team. There are also a number of other opportunities becoming available such as Amber House, which is a dual crisis residential/crisis stabilization unit. The county wants to ensure the proposed project is implemented correctly, and then use MHSA funding and Medi-Cal to sustain it.

Ms. Hazelton stated another test is to see if Whole Person Care, EMS, and the proposed project could form a successful partnership and what that would look like moving forward.

Commissioner Danovitch stated it appeared that the labor and the operational costs of running the proposed Innovation project is the part that is being funded in the budget, not the partnership. He stated those are the things that need to be funded to be able to sustain it. He asked about the process for making the decision to support the proposed project on an ongoing basis and if the county would move the project forward with or without the funding.

Ms. Hazelton stated money was put in for evaluation. She stated there is also an MHSA stakeholder group comprised of one-third family members, one-third consumers, and one-third providers, which will be intimately involved. They will have decision-making power as to the project's level of success. As the years go on in the project, the county will continue closely tracking that and have benchmarks of success. She stated the behavioral health leadership will ultimately make that decision with input from the evaluators, the MHSA stakeholder committee, and others.

Commissioner Mitchell asked if the project proponents had looked at the Innovation project Los Angeles County presented to the Commission, because it is very similar.

Dr. Sporer agreed that the Los Angeles County's Innovation plan is similar, but they have a registered nurse and an EMT. He stated Alameda County has the luxury of being more integrated and collaborative.

Commissioner Bunch stated a huge difference between Los Angeles and Alameda County's Innovation plans is the ReddiNet System.

Emotional Emancipation Circles for Young Adults

Lisa Carlisle, MA, MEd, Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care, provided an overview, with a slide presentation, of the problem, proposed Innovation project, innovative components, and evaluation of the proposed Innovation project.

Shannon Singleton-Banks, MPH, Senior Program Specialist for Alameda County's Public Health Department, continued the slide presentation and discussed the budget and sustainability of the proposed project.

Commissioner Questions

Jordan Bouskos asked how youth can find out about the proposed project.

Ms. Singleton-Banks stated youth do not always attend county programs. She stated the plan is to do outreach to meet youth where they are.

Commissioner Anthony stated she was excited that the age group for this project is 18 to 30. She stated so many individuals drop off after age 24. She stated the hope that the project would include young men in the program.

Ms. Singleton-Banks stated the pilot had a balance of young men and women. She stated the plan is to launch three coed groups, one male group, and one female group.

Commissioner Mitchell asked how many individuals the program will serve. She stated concern about the low budget. She encouraged the county not to be afraid to ask for what it needs.

Ms. Singleton-Banks stated the project anticipates reaching approximately 120 young people through the course of the pilot.

Public Comment

Jeanette Dong, Director, Recreation and Human Services, City of San Leandro, spoke in support of the proposed CATT project.

Jeff Tudor, Police Chief, San Leandro Police Department, spoke in support of the proposed CATT project.

Tyler Rinde, Legislative Analyst, CBHDA, spoke in support of the three proposed projects.

Rebecca Rozen, Regional Vice President, Hospital Council, spoke in support of the proposed CATT project.

Nicolette Efstathion, spoke in support of the proposed Introducing Neuroplasticity to Mental Health Services for Children project.

Nicholas Efstathion, spoke in support of the proposed Introducing Neuroplasticity to Mental Health Services for Children project.

Desire Johnson-Forte, Founder, Black Integrational Zeal (BIZ) Stoop, spoke in support of the proposed Emotional Emancipation Circles for Young Adults project.

Ashlee Jemmott, Peers Envisioning – Engaging, spoke in support of the proposed Emotional Emancipation Circles for Young Adults project.

Steve Leoni spoke in support of the proposed Introducing Neuroplasticity to Mental Health Services for Children and Emotional Emancipation Circles for Young Adults projects and suggested that the county speak with Janet King. The speaker was disappointed that the CATT program did not include peers.

Rory O'Brien spoke in support of the proposed Introducing Neuroplasticity to Mental Health Services for Children project, although the speaker asked that Commissioners consider how responsive HANDLE assessments and interventions will be for youth who are experiencing continuous or concurrent trauma, where brain plasticity is adaptive to trauma, and where these adaptations are geared specifically to support youth to survive those ongoing traumas. The speaker asked how HANDLE’s interventions and their assessments support the neurodevelopmental goals in the context of the ongoing utility of fight, flight, and freeze responses.

Rory O'Brien spoke in support of the proposed Emotional Emancipation Circles for Young Adults project. The speaker questioned how youth participants will be involved in determining and leading their own emotional emancipation.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, spoke in opposition to the proposed CATT project. Four of the six MHSA general standards are not being upheld. The speaker questioned whether there was a meaningful community planning process. It is concerning that no peer positions were funded in this type of program. A truly innovative program must begin with a truly meaningful community planning process. The speaker suggested, in order to meet people where they are, having a peer be part of the first responders, leading the multidisciplinary teams. There is a need for this type of program, but the way it was done did not uphold the intent of the MHSA in order to do business differently and better.

Poshi Walker spoke in opposition to the proposed CATT project. The speaker agreed with the comments made by Andrea Crook.

Poshi Walker spoke in support of the proposed Emotional Emancipation Circles for Young Adults project. The speaker was happy that there was an Innovative project from the CRDP. All counties should be looking at the CRDP reports, which call out a variety of Innovative projects.

Poshi Walker stated peers should be involved throughout the process, beginning with the community planning process, during the project, and through evaluation. The speaker asked the Commission to question the county on whether they considered having a peer support specialist as part of the interdisciplinary team that goes to meet individuals who are in crisis. Sometimes it is a peer and not a clinician who can reach that person.

Poshi Walker stated the MHSA is about the recovery model, not the medical model. The speaker agreed that there is a need, but the presenters talked about 5150, where to divert the 5150 individuals, and how to get them out of emergency departments, which sounds more like a medical model than a recovery model. The MHSA and the recovery model emphasize peer support. The speaker referred to the part of the proposal that indicated that consumers will be given stipends at the evaluation while the CATT teams will be given salaries. Salaries mean meaningful employment. The speaker stated there is not a meaningful engagement of peer support specialists.

Thavery Hou, Outreach Worker, Center for Empowering Refugees and Immigrants (CERI), spoke in support of the proposed projects.

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

The MHSOAC approves Alameda County's Innovation Project as follows:

Name of Project: Introducing Neuroplasticity to Mental Health Services for Children

Amount: $2,054,534

Project Length: Four (4) Years

Motion carried 4 yes, 3 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Beall, Gordon, and Mitchell.

The following Commissioners voted “No”: Commissioners Ashbeck, Bunch, and Madrigal-Weiss.

Commissioner Discussion

Commissioner Ashbeck referred to the proposed CATT project and encouraged including additional metrics and looking at the savings to the system. It is not enough if the project saves money for hospitals but costs the police department more. She also suggested including a metric on repeat visitors.

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

The MHSOAC approves Alameda County’s Innovation Project as follows:

Name of Project: Community Assessment and Transportation Team (CATT)

Amount: $9,878,082

Project Length: Five (5) Years

Motion carried 6 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Ashbeck, Bunch, Gordon, Madrigal-Weiss, and Mitchell.

The following Commissioner voted “No”: Commissioner Beall.

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

The MHSOAC approves Alameda County’s Innovation Project as follows:

Name of Project: Emotional Emancipation Circles for Young Adults

Amount: $501,808

Project Length: Two (2) Years, Six (6) Months

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

The following Commissioners voted “Yes”: Commissioners Anthony, Ashbeck, Beall, Bunch, Gordon, Madrigal-Weiss, and Mitchell.

Vice Chair Aslami-Tamplen rejoined the Commissioners at the dais. She resumed chairing the meeting.

ACTION

5: San Francisco County Innovation Plan

Presenters:

- Stephanie Felder, M.S., Director, Comprehensive Crisis Services, San Francisco Department of Public Health
- Amber Gray, Health Worker III, Peer Specialist, San Francisco Department of Public Health
- Charlie Mayer-Twomey, LCSW, Project Administrator, Hathuel Tabernik and Associates

Wellness in the Streets

Stephanie Felder, M.S., Director, Comprehensive Crisis Services, San Francisco Department of Public Health, provided an overview, with a slide presentation, of the need for the proposed Innovation project.

Amber Gray, Health Worker III, Peer Specialist, San Francisco Department of Public Health, continued the slide presentation and discussed the outreach process.

Charlie Mayer-Twomey, LCSW, Project Administrator, Hathuel Tabernik and Associates, continued the slide presentation and discussed the Community Needs Assessment, stakeholder engagement process, proposed project to address the need, and innovative components.

Ms. Gray, a certified Wellness Recovery Action Plan (WRAP) instructor, spoke about her experience and how the WRAP program might work well in the streets.

Ms. Felder spoke about her work on the streets and how the proposed project may increase collaboration with Comprehensive Crisis Services. She stated the component that is missing is the peer-to-peer interventions. The proposed project will help fill that gap.

Mr. Mayer-Twomey continued the slide presentation and discussed the evaluation, budget, and sustainability of the proposed project. He showed a video presentation by Tracey Mitchell-Helton, Manager, Peer-to-Peer Services, San Francisco, who was unable to be in attendance today.

Commissioner Questions and Discussion

Commissioner Anthony asked how the proposed project partners with the DHCS and how it will facilitate the process of establishing and receiving Medi-Cal, CalFresh, and supplemental security income (SSI) for individuals who are on the streets and disconnected.

Mr. Mayer-Twomey stated the county will convene and participate in committees and workgroup meetings to discuss how to be a part of the bigger picture and to seek other funding sources. He stated the hope to test new ways to meet the needs of these individuals so that successful components of the project can be sustained in the future. He noted that the new mayor is placing an emphasis on working with this population.

Commissioner Mitchell stated the need to find opportunities to grow projects like this because they are so needed.

Commissioner Madrigal-Weiss stated she appreciated the restorative nature of the design of the proposed project – doing things with the people and not coming in with assumptions and a pre-set list of what is available. The reality is every story is unique. In general, county services and programs make assumptions as to why individuals are in these situations. She stated she appreciated the fact that the proposed project approaches individuals with questions and walks the path with them instead of doing things to them or at them.

Commissioner Ashbeck stated she cannot believe that the city that has tried, perfected, and mastered caring for the homeless has not just talked to them. She stated housing was not presented as an outcome. Perhaps an individual does not want to live in a house or does not have that need today. It is an interesting switch that most of this work across the country is about getting individuals housed, but maybe that is not the right solution. She stated she was stunned that the county had not thought about meeting individuals where they are, but she thanked the county for changing their experiences into ways to help others.

Commissioner Beall stated there are approximately the same number of homeless individuals in San Jose as in San Francisco. He stated San Jose is working with the California Department of Transportation (Caltrans). He asked if Alameda County has a relationship with Caltrans and if the term “streets” includes under freeways and other places where homeless individuals are.

Commissioner Beall stated he introduced SB 519 this year for Los Angeles and San Jose. San Francisco already has a law where an individual can lease a piece of property for a dollar per month for Caltrans land. He asked if the county is doing navigation of people that need a place to stay when the weather turns cold or rainy to under freeways or into some kind of shelter and if the county is working with Caltrans on that.

Ms. Felder stated she has not been part of meetings working with Caltrans. There are emergency shelters available during inclement weather and the county has navigation centers.

Commissioner Beall stated he has been pressuring Caltrans to directly fund navigation centers. He stated, as the Chairman of the Senate Transportation Committee, he would like to see Caltrans do a better job working with groups like the San Francisco Department of Public Health to help individuals make their lives better rather than to just ask individuals to stay off of their property. He stated Caltrans donated $10 million for that purpose and the Senate Transportation Committee will try to get more over the next few months. He stated certain ballot measures will also help individuals in these areas.

Jordan Bouskos thanked the county for approaching the homeless population as individuals who can be helped rather than a problem to be solved.

Public Comment

Tyler Rinde spoke in support of the proposed project.

Michael Sullivan spoke in support of the proposed project.

Jose Luis Orbeta spoke in support of the proposed project.

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

The MHSOAC approves San Francisco County's Innovation plan as follows:

Name: Wellness in the Streets

Amount: $1,750,000

Project Length: Five (5) Years

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

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

INFORMATION

6: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Transparency Tool

The County Revenue and Expenditure Reports have been posted online. Staff is working on another component which will list out information on approximately 1,500 community mental health programs.

Commissioner Questions

Commissioner Mitchell asked who the Transparency Tool will most help.

Executive Director Ewing stated, in 2016, the Little Hoover Commission raised concerns that the MHSOAC was not promoting oversight and accountability. The MHSOAC presented testimony to the Little Hoover Commission that it was working on a three-prong strategy through the Transparency Tool:

- To give the public clear information on funding.
- To give the public clear information on programs. Counties are required to provide the MHSOAC with demographic information for the individuals they serve. In the future, the tool will include not only what the PEI and Innovation programs are, but who counties say they serve and who they actually serve.
- To give the public clear information on outcomes.

Executive Director Ewing stated the goal of the Transparency Tool is to provide the public with information on the money, the programs currently in place, who those

programs are serving, and how well those programs are achieving the outcomes in the MHSA.

Executive Director Ewing stated as part of transparency, we are working on linking mental health and Full Service Partnership data with criminal justice data to show whether or not criminal justice involvement rates have gone down, which is what the law expects. Staff is vetting that the data linkage information with subject matter experts and policy and programmatic experts. Staff is also working with the Department of Education to link mental health data with education data, and working with the Employment Development Department to link mental health data with employment. Currently, there is only a limited component of the mental health data, that of the Full Service Partnership.

Executive Director Ewing stated staff has also taken the Client and Service Information (CSI) System dataset, which has information on everyone who was served and has mapped race and ethnicity against that to compare to Medi-Cal race and ethnicity data and the overall population's race and ethnicity data to see if disparities are being addressed.

Executive Director Ewing stated there are concerns about the core data that the DHCS has provided to the Commission. Staff is going through a process with subject matter experts on where the data comes from, if it is reliable and valid, how reliable or valid it needs to be in order to be used, and if the data is so inaccurate that it is a disservice to try to analyze it. The broad answer is that staff has thought about this as a tool to support the community engagement process, but is finding that counties are using the information in ways that support what they are trying to do.

Executive Director Ewing stated the law requires counties to submit a financial report. If they do not submit a report, the state can withhold funds. Based on the report, funds will be reverted based on lack of use after three years. In 2012-13 and 2013-14, none of the counties submitted their reports on time. Currently, 24 percent of counties have submitted them on time. Approximately 80 percent of those submitted their reports within the six-month window following the statutory deadline. There had been no withholding of funds based on failure to submit a report, but the state has now withheld funding from four counties.

Executive Director Ewing stated Assembly Bill (AB) 114 was a one-time reset of the reversion clock for approximately $280 million of unspent funds that expired last year. The first time that funds will revert would be based on the fiscal reports that are due this December 31st. By the first quarter of next year, reversion will begin happening.

Executive Director Ewing stated, through the Fiscal Transparency Tool, counties are improving the reporting and enhancing the data that is available. Gaps are expected in the Fiscal Transparency Tool the first time out, but the quality of the data will go up as the tool is used.

Executive Director Ewing stated, as the reporting has gotten better, staff is now looking at the amount of Innovation funds that have come in and the amount of Innovation funds the Commission has approved to be spent. Upon subtraction, there should be a certain amount of funding left. The issue is that the calculated funding that should be left does

not align with the county fiscal reports. There are anomalies in several counties between their Innovation spending and what the Commission has approved for their Innovation plans.

Executive Director Ewing stated staff is researching whether that is an oversight because of ambiguity in the law where at one point the state approved Innovation spending, at another point the state did not approve it, and then began approving it again. There was a period of transition where the Commission issued two information notices and then the rules changed and created conflict. Staff is researching if those patterns are because of Commission changes or state law changes, and is trying to reconcile staff's calculations to the counties' fiscal reports in order to present a proposal to the Commission. For example, like AB 114, one of the proposals might be retroactive approval of money that has already been spent versus reimbursing the Innovation funds with other funds. It is not clear whether the Commission has the authority to do a retroactive approval. Staff has more research to do on that.

Commissioner Mitchell asked for more details about the change in the law.

Executive Director Ewing stated the change in the law was in 2012. It was a six-year period that staff is only now learning about primarily because county reporting has gotten better.

Commissioner Mitchell asked about putting Innovation plans on the agenda in consent.

Executive Director Ewing stated that topic had come up in the Commission and staff has had discussions internally. One of the Alameda County plans was a potential candidate for consent, but staff felt that the Commission should discuss the potential criteria for consent and get public comment on the process prior to presenting a consent proposal to the Commission.

Innovation Incubator

The Commission received a $5 million authorization to sponsor an Innovation Incubator. Staff held a public forum a couple of weeks ago and is reviewing a proposal put together by the consultant. A report will be presented at the November meeting. One of the issues raised by counties is the need for a clearinghouse or learning community around the core mental health programs around the state. Quite often, the Commission sees patterns in terms of how counties are investing or designing their mental health systems.

One of the requests made in the discussion around the Innovation Incubator is if the state could support the development of a clearinghouse or a broader learning community, not specific to innovation but more broadly defined to help them understand what works around the state and around the country, and to provide the kind of technical assistance and support that effective evidence-based or community-based practices would need in order to move to scale. That question will be put on the table at next month's Commission meeting.

Innovation Plan Review and Approval

Staff has been successful in helping counties to generate five different collaborative Innovation proposals. One of them is the Incompetent to Stand Trial work that the governor has asked the Commission to focus on through the Innovation Incubator. A multi-county collaborative will present an Innovation plan to develop early psychosis programs at the November or January Commission meetings.

Mental Health Policy Fellowship

The fellowship has been named and an advisory committee will be appointed by October 31st through an online application process to help determine the selection process, required number of hours per week, responsibilities, compensation, health insurance, etc., for the fellowship program. A progress report will be presented in the spring and the program will launch towards the end of next year.

Speaking Engagements

Staff was invited to participate in a documentary on the issue of youth in mental health crisis with Ken Burns.

Staff met last week with a delegation of mental health leaders in Ventura County. Public Health Advocates asked the Commission to partner on the All Children Thrive Initiative, which was funded this year.

Staff will speak next month at the California Academy of Child and Adolescent Psychiatry and NAMI conference in the Bay Area.

The West Hills Community College District has a mental health workforce conversation in Coalinga.

Staff will accompany the Legislative Budget Committee on a site visit to the Golden Gate Bridge on November 9th as part of the suicide net development project.

Commissioner Brown and staff will be speaking at the November Words to Deeds conference in Los Angeles.

Staff has been invited to speak at an Organization for Economic Co-operation and Development (OECD) global conference in November in Korea.

Staff has been invited to speak at an American Psychiatric Association meeting in May of 2019 in San Francisco. Commissioner Danovitch may also speak at this meeting.

Stakeholder Contracts

There has been a series of meetings to discuss the best use of the immigrant/refugee dollars received in the budget this year. Approximately $2 million will be made available for a three-year advocacy effort on behalf of the mental health needs of immigrants and refugees. A proposal for a competitive process to make those funds available in the community will be presented at the January 2019 Commission meeting.

Staff is in the process of working to review the work product of the existing seven stakeholder contracts. Each contractor is required to write a state-of-the-state report based on the population that they are working on. Chair Boyd asked staff to put one of

the seven stakeholder contractors on the agenda each month, but that became difficult with the dramatic increase in Innovation proposals.

Commissioner Questions

Commissioner Anthony asked when the state-of-the-state reports are due from the contractors. Executive Director Ewing stated they are in the process of coming in and all but one has been submitted.

Suicide Prevention Plan

Yesterday and today, the Commission convened panels on suicide prevention. The intent is for the subcommittee to draft a potential Suicide Prevention Plan for the State of California. That draft will go to the subcommittee for review and revisions. This is an opportunity for input, feedback, and vetting of the proposals that the staff will bring together based on the work done, with direction from the chair. If approved, the draft will be presented to the Commission, which will present another opportunity for public review and vetting. After adoption of the plan, it will move into an implementation phase, working with the administration and the Legislature to make the recommendations in that plan a reality.

Triage Grants

The Commission had to reduce the triage grant allocation by 29 percent and is in the process of negotiating with all counties how they might accommodate the 29 percent cut in their budget proposals. Some counties have been able to supplement the funding the Commission has given with their own dollars while other counties have not. One county has opted not to receive the funds. Staff has engaged counties in a series of negotiations on a case-by-case basis in order to accommodate those dramatic cuts. An update will be provided to itemize the arrangements made to recognize the 29 percent cut at a future Commission meeting.

Commission Meeting Calendar

Every month, staff sits down in consultation with the chair to look at staff workload between the large policy projects and Innovation plans, and tries to include other components based on what is timely and the other work that must be done.

The November Commission meeting is a two-day meeting at the Mission Inn in Riverside with the Commission meeting on Wednesday, which will be focused on Innovation plan reviews and approvals along with other items. The Thursday meeting will focus on strategic planning.

The January Commission meeting will include discussions on the budget and legislation. One of the questions that has come up is how to move forward on the peer certification bill that the Commission took a leadership role on. Staff will confer with the chair, vice chair, and Senator Beall, who authored the bill this year on peer certification, about opportunities to revisit that issue in recognition of the Governor's veto.

In January, staff will ask the Department of Finance to present the Governor's Budget Proposal to the Commission to get a sense of the priorities that are in place, recognizing that this is an election year.

Public Comment

Stacie Hiramoto commended the Commission and staff for conducting listening sessions on the immigrant/refugee stakeholder RFP but questioned the fact that advocacy will play a lesser role for the immigrant/refugee stakeholder contract. The speaker recommended that the Commission consult and collaborate with the Department of Public Health's Office of Health Equity and Office of Refugee Resettlement because they have done the CRDP and are the experts.

Stacie Hiramoto suggested that the Commission use the best practice regarding RFPs to allow a 30-day public comment period on the outline of the RFP. The RFP is developed after the public provides feedback on the aspects of the RFP, not just that the public answers the question about the needs of refugees and immigrants.

Beatrice Lee, Executive Director, Diversity in Health Training Institute, stated there was a discussion at the September Commission meeting on county Innovation grants that were suspended due to a technicality with regard to plans that expired in fiscal year 2015, thus impacting all Innovation funds that were spent or are in process throughout fiscal year 2019. The speaker voiced concern over the cancellation of the Alameda County Innovation mental health pilot projects, which were aimed at increasing access and utilization of mental health services for underserved populations through community-driven innovative technology and stigma-reducing programs designed by and for these communities.

Beatrice Lee stated eight technology grants that were awarded by Alameda County in March and May of 2018 and the Asian American/Native Hawaiian/Pacific Islander/Refugee/Asylee RFP for multiple projects that was issued in April of 2018 and targeted to begin this fall were cancelled due to an MHSOAC administrative fiscal technicality impacting Innovation grants from fiscal years 2015 through 2019. There is much at stake for these communities as well as for the mental health field. These grants target communities that either have low penetration rates or have no data because these are merging communities, many of whom are immigrants and refugees.

Beatrice Lee stated the understanding that the MHSOAC may require Alameda County to repeat stakeholder interviews. This is not necessary as the grantees who applied and were awarded have already done that and incorporated the community input into their program designs. The speaker did not want Alameda County to wait any longer before rolling out these programs.

Beatrice Lee distributed a letter containing the full comments of the Diversity in Health Training Institute.

Anupam Khandelwal, SageSurfer, spoke in support of restoring the Innovation technology grant funds.

Linnea Ashley, Training and Advocacy Director, Youth ALIVE!, spoke in support of restoring the Innovation technology grant funds.

Tawny Porter, Diversity in Health Training Institute, spoke in support of restoring the Innovation technology grant funds.

Elijah Chhum, Outreach Worker, Center for Empowering Refugees and Immigrants (CERI), spoke in support of restoring the Innovation technology grant funds.

Ei Ei Phoo, CERI, spoke in support of restoring the Innovation technology grant funds.

Prim Pariyar, Diversity in Health Training Institute, spoke in support of restoring the Innovation technology grant funds.

Bimash B. Shrestha, Nepali and Bhutanese communities, spoke in support of restoring the Innovation technology grant funds.

Nafisa Junahan, OHTI, spoke in support of restoring the Innovation technology grant funds.

Chris Cara, Filipino Advocates for Justice, spoke in support of restoring the Innovation technology grant funds.

Min Roh, KCCEB, spoke in support of restoring the Innovation technology grant funds.

Commissioner Discussion

In response to a question from Commissioner Gordon, Beatrice Lee stated there are two grants referred to during the public comment period: a technology Innovation grant and the Asian American/Native Hawaiian/Pacific Islander/Refugee/Asylee RFP. The speaker stated Alameda County was told to begin implementation of the program in May, but then received a letter in August saying that the whole program was canceled, effective immediately. The other issue has to do with an RFP that was released but is now on hold. The speaker requested that these issues be resolved.

Vice Chair Aslami-Tamplen stated the Commission staff has been working with the county to resolve it.

Ms. Hazelton addressed the question of what the county explained to the communities. The county was contacted by the Commission in January inquiring about the Innovative grant program. She stated she provided information to Mr. Kukal, who is no longer with the Commission. She stated she did not hear back from him until June, when she started speaking with Commission staff, Dr. Sharmil Shah. Ms. Hazelton stated she understood at that time that there was an issue with the Innovative grant program. County staff and leadership who started the Innovation grant program in 2010--11 are no longer with the county. She stated she learned about the issue from Commission staff.

Ms. Hazelton stated she and the Innovation coordinator came to Sacramento and met with Commission staff, who informed them that the county did not have approval to spend the Innovation funding for the Innovative grant program because the county did not request nor received any type of approval or extension from the Commission. Alameda County originally had approval for two rounds of grants. At the meeting in Sacramento, Commission staff told her that they would try to create a path forward for funds that have already been spent, potentially through a retroactive approval process, if that is possible. Nothing was promised, but it was a directive to the county that, if the county has projects in the Innovative grant program and has not yet spent the money, the money cannot be spent.

Ms. Hazelton stated she and the Innovation coordinator went back to the county and rescinded the contracts for the technology grants. The contracts had not yet been signed. She stated the county does not have evidence that the MHSOAC was directly monitoring Alameda County. There was a time period in 2011-12 where there were different Innovation notices that became confusing. Alameda County did not know of any issue with approval until Mr. Kukal contacted the county in January asking for the final report.

Vice Chair Aslami-Tamplen asked if there is a plan to bring those Innovation plans to the Commission.

Ms. Hazelton stated, if the county does, it would have to start over, which is at least one year out, and the county has another proposal it is currently working on. It would most likely be a year and a half before the county would have the capacity to bring them back.

Executive Director Ewing asked Ms. Hazelton to lay out what the 18-month process would be.

Ms. Hazelton stated the county currently only has the capacity to work on one Innovation program at a time. The county will meet with Commission staff in early November on another project, which will be released for public comment in December. That process must be completed before beginning work on a new technology project.

Ms. Hazelton stated the county has had a meeting with Commission staff around technology and staff suggested not bringing a technology project forward right now because the Commission had approved two rounds of technology suites and there is not yet evidence that those projects will be successful. The county has a lot of data at the local level where technology apps were going to have a benefit, some of which were in specific languages.

Executive Director Ewing stated it sounds like the primary concern is the county's local capacity to get the proposal through the internal process, local mental health board, and local board of supervisors. Any effort on the Commission's part to move the county up the queue would create challenges to local capacity.

Ms. Hazelton agreed.

Ms. Yeroshek suggested putting this issue on the agenda for a Commission meeting to allow for more discussion. The current public comment is limited to the executive director report out, which includes reports and the dashboard on Innovation spending.

Commissioner Anthony stated the Commission had mentioned previously that it would reconvene the subcommittee on Innovation. She volunteered to participate on that subcommittee.

GENERAL PUBLIC COMMENT

Steve Leoni stated the question was brought up during yesterday's table discussion about where individuals who give out a lot of help to others go for help. This raises the

issue of where leaders go for help. The speaker saw a segment of the PBS News Hour talking about physicians and suicide and how there is a great resistance among physicians to being seen as having a mental health issue. The news program stated that male physicians are 40 percent more likely to commit suicide than their equivalents in the population, and female physicians are 200 percent more likely to commit suicide than their equivalents in the population. The speaker suggested looking at suicide patterns among leaders and physicians when compiling the Statewide Suicide Prevention Plan.

Peggy Rahman, President, NAMI of Alameda County, spoke in support of restoring the Innovation technology grant funds. She asked if the county has to go through the stakeholder process again in order to get the technology Innovation grant funded.

Stacie Hiramoto encouraged the Commission to read the letter submitted by Beatrice Lee. The Commission bears some responsibility and there are things it can do, not just Alameda County. The speaker did not feel this would happen to any other minority group. It is difficult for the API community to come forward.

Tracy Kennedy, 2nd Story Peer Respite House, asked the Commission to communicate to Santa Cruz County on what PEI funding can be used for and if it can be used to fund the peer respite. The speaker asked to see clear guidelines around funding peer respites so that the challenge for funding will not be faced by other peer respites. It is important to have funding set aside for peer respites.

Cindy Phoenix, 2nd Story Peer Respite House, advocated for peer respite for health and healing in times of mental health crises. The speaker asked for a dedicated funding category to support peer respites.

Erika Miranda, 2nd Story Peer Respite House, stated they were in attendance to hold the Commission accountable to the stakeholders who are psychiatric survivors, peers, and consumers and ask that peer support and peer respites be explicitly and clearly prioritized through the MHSA via the MHSOAC.

Bishop Joseph Eaton advocated for peer respite and peer outreach teams so that individuals can find support where they would not otherwise find it, especially those who choose not to be identified.

Adrian Bernard advocated for peer respites and stated the hope that MHSA funds can provide support for peer respites. It is necessary to have a consistent funding stream for empowerment. The speaker stated the need for clear legislation that speaks to the problem of NIMBYism.

ADJOURN

There being no further business, the meeting was adjourned at 5:42 p.m.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplen
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION
STRATEGIC PLANNING SESSION

Minutes of Meeting
September 26, 2018

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

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Tina Wooton

Members Absent:

Senator Jim Beall
Assemblymember Wendy Carrillo
Gladys Mitchell

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

DAY 1: September 26, 2018

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Strategic Planning Session to order at 9:27 a.m. and welcomed everyone. He asked Vice Chair Aslami-Tamplen to share her opening comments.

Vice Chair Aslami-Tamplen provided a brief overview of her background and experiences on the Commission over the past six years and the recent projects undertaken by the Commission.

Chair Boyd reviewed the agenda for the next two days. He stated the work of the Commission could not be more important. He stated general society appears to be more at a state of disease than ever before. He stated uncertainty that the Commission is living up to the expectations of the voters in California for Proposition 63, the Mental Health Services Act (MHSA), which established this Commission. He stated he was not confident in the direction of the Commission, if left unchecked.

Chair Boyd stated the Innovation plan approval process does not work. It does not serve the counties or the stakeholder consumer voices who are trying to work with a broken process. It is not meaningful; it does not make a difference. The Commission puts out white papers but he questioned whether counties are using them. He asked if the Commission is driving the behind-the-scenes advocacy to effect change. The Commission spends a lot of time, but he asked if it meets needs and leverages more stakeholder voice.

Chair Boyd stated the Commission's role is to advise the Governor and the Legislature and yet has done that only once in five years. He asked if the Commission is responsible for connecting to local mental health boards and ensuring that their voice and the voice of local stakeholders are heard. He asked if it should be the Commission's role to make them more successful – to listen and ask them what tools they need to do their jobs more effectively at the local level. He asked for a raise of hands of participants who are representatives of a local mental health board. One individual from Napa raised their hand.

Chair Boyd stated we need to closely listen to those local county board voices. What do they need to be successful? How does the Commission empower the stakeholder voice at that level? How does the Commission ensure it gives voice in the Commission meetings and in the Commission's work to those voices? That must be asked as strategies are designed.

Chair Boyd stated, at the end of the day, the Commission can pull the Department of Health Care Services (DHCS), stakeholders, Commissioners, peers, consumers, and county directors together and set standards, mandate those standards, and hold individuals accountable. That is oversight and accountability. He stated he wanted to see the Commission put together structures to ensure it is able to do that. He stated the need to clearly define what successful outcomes are, mandate those, and ensure that they are informed truly by the collective voice of stakeholders and consumers at every level of the state along with the expertise of the Commissioners.

Chair Boyd stated today's focus is to determine the strategy for the next two to three years to ensure that California is a good steward of its incredible responsibility to the MHSA. He thanked everyone for their willingness to participate in the process.

Roll Call

Chair Boyd asked for the roll call.

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Ms. Yeroshek announced that the telephone is on listen only for the morning session and individuals will be unable to listen in to the afternoon break-out session because participants will be divided into groups for discussion. The telephone will be back on for the reporting out of those break-out groups.

STRATEGIC PLANNING SESSION OVERVIEW

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Filomena Yeroshek, Chief Counsel
- Lynne Ashbeck, Commissioner

Bagley-Keene Presentation

Ms. Yeroshek provided an overview, with a slide presentation, of the requirements of the Bagley-Keene Open Meeting Act. She stated staff will be taking photographs and making videos throughout today's meeting to be used in publications and on the website. She asked anyone who would not like their photograph taken to contact staff.

Questions and Discussion

Commissioner Ashbeck asked how the Brown Act compares to the Bagley-Keene Act for individuals in local government, and if the Bagley-Keene Act contains language about what constitutes a quorum.

Ms. Yeroshek stated the Commission's Rules of Procedure discusses the definition of a quorum. One of the biggest differences between the Brown Act and the Bagley-Keene Act is the amount of public notice that is required. There is only a 72-hour public notice requirement in the Brown Act versus the Bagley-Keene's 10-day requirement. The Brown Act has many details that are not specified in the Bagley-Keene Act such as the agenda having to be posted at the site of the meeting.

Lynne Ashbeck

Commissioner Ashbeck stated the comments of the chair and vice chair reflect the spirit of today, which is to achieve the highest and best use of this Commission for those it serves, the counties, and the taxpayer funding. She stated all the answers will not be found today but hopefully ways can be found to elevate the work to serve the needs of Californians.

Due to the fact that there are many newer Commissioners, Commissioner Ashbeck suggested a review on how Commissioners should behave collectively in the interest of those the Commissioners are trying to serve.

Executive Director Ewing

Executive Director Ewing reviewed the direction of the Commission and projects that have been conducted over the past year. He stated the Commission wanted to step back and revisit the foundation that should guide and shape the work it does. In addition to having new Commissioners, the Commission has had new opportunities and new obligations.

Executive Director Ewing stated there are areas where the Commission is successful and areas where it struggles. These areas will be put on the table today and Commissioners will be engaged through a process that extends well beyond today. He stated the need to step back and remind Commissioners of why they are here, of what the opportunity is, and of the challenge of ensuring that the obligation of the Commission - which is to promote transformational change – is met.

Executive Director Ewing stated the value and structure of the Commission that brings stakeholders together is an opportunity to leverage the political capital that must be leveraged to

improve the mental health system in dramatic ways. The MHSA is unusual to have a policy vision in that California has a mental health system that is heavily driven by prevention and early intervention opportunities. It is rare to have a mandate for prevention and the money to go with it.

Executive Director Ewing stated the other unusual piece of the MHSA is that every county is required to take risks to try new things. It is a built-in mechanism for continuous improvement. He noted the difference in the Commission workload of two years ago where the Commission reviewed 11 plans in the calendar year versus the 80 to 90 plans that are currently in the queue.

Executive Director Ewing stated today is an opportunity to step back and to hear where the Commission is developmentally, where it needs to be, the aspects of the work that should be prioritized, the aspects of the work that there is no time for and are not effective, and the aspects that need to be enhanced collectively. He stated, over the course of a year and with the guidance of the Applied Survey Research Team, staff wants to ensure that their time and energies are dedicated to Commissioners' priorities to be as effective as possible.

STRATEGIC PLANNING SESSION

Presenters:

- Susan Brutschy, President, Applied Survey Research (ASR)
- Lisa Colvig-Niclai, Vice President of Evaluation, ASR
- Samantha Green, Project Manager, ASR
- Kendra Fisher, Research and Administrative Assistant, ASR

Executive Director Ewing introduced Susan Brutschy, who will facilitate today's strategic planning session.

Susan Brutschy, President, ASR, introduced the members of her team and reviewed the agenda, plan, and goals for the day. She gave a brief overview of the background of the ASR. She asked Commissioners to introduce themselves and share their passion and drive for this work.

<u>Commissioner Introduction</u>

Commissioner Gordon, Sacramento County Superintendent of Schools, stated his passion is a focus on early intervention. What is typically considered as early intervention is, in fact, far too late.

Commissioner Danovitch, Chair, Department of Psychiatry, Cedars-Sinai Medical Center, stated his passion is a focus on early intervention. He stated he also is interested in the fragmentation in the system as a barrier to providing care to individuals. California has rich resources but those resources often do not communicate or coordinate. He stated he would like to see the Commission help promote a system in California that touches individuals and helps catch them in the areas where they tend to slip through the cracks.

Commissioner Danovitch stated it is important during today's strategic planning session to take the opportunity to discuss how the Commission does what it does.

Commissioner Ashbeck, Senior Vice President, Community Engagement and Population Health, Valley Children's Healthcare, and Elected Councilmember, City of Clovis, stated her

passion is to build stronger local capacity and strong systems of care where people live and give people a voice in the places where they call home.

Vice Chair Aslami-Tamplen, Consumer Empowerment Manager, Alameda County Behavioral Health Care Services, stated her passion is the people the Commission serves, the system being focused on wellness and recovery, and the underserved, unserved, and inappropriately served communities. Vice Chair state she also is passionate about ensuring that everyone in those communities has a voice, that the system is guided through their leadership, and peer specialist certification.

Chair Boyd, Chief Executive Officer of Mental Health Services, Sutter Health, stated his passion is that California does a phenomenal job to ensure that anyone suffering from a mental health challenge in the workplace, school setting, community setting, or streets is able to navigate that easily without the effort that happens today that becomes a barrier to care, and to change the narrative for mental health in California so social prejudice and stigma are no longer barriers to accessing care.

Chair Boyd stated he also is passionate about handing off the leadership of this Commission to drive the Commission forward to lead the public and to strengthen the dialogue around how California can be effective for everyone.

Commissioner Anthony, Executive Director, A3 Concepts, LLC, stated her passion is persons who are considered seriously mentally ill and their family members. It is important to stay focused on illness, wellness, and recovery in all aspects of the work the Commission does.

Commissioner Bunch, Clinical Psychologist, Emergency Outreach Bureau, Los Angeles County Department of Mental Health, stated her passion is to advocate for more programs that will make a difference for underserved communities.

Commissioner Alvarez, President, Children's Partnership, stated her passion is to ensure that low-income, particularly marginalized communities, have access to the services that they need. Health is a social justice issue that is connected to every aspect of life. She stated she is particularly motivated by today's environment and what it is doing to the mental health and wellbeing of children and families.

Commissioner Madrigal-Weiss, Director, Wellness and Student Achievement, San Diego County Office of Education, stated her passion is prevention and building capacity of school communities. She stated she is also an advocate for building capacity of youth and teaching youth how to do things for themselves.

Commissioner Brown, Sheriff and Coroner for Santa Barbara County and immediate past president of the State Sheriffs' Association, stated his passion is for keeping individuals with mental health issues out of the criminal justice system as much as possible, and doing a better job of treating individuals with mental health issues who have to be in the system due to other circumstances.

Strategic Planning Overview

Ms. Brutschy provided an overview, with a slide presentation, of the strategic planning process. She stated the ASR will not necessarily do a traditional strategic plan but will approach it with a results-based focus. She stated one of the most important purposes of today's session is to establish a common language about the Commission's goals, priorities, and results so that Commissioners can carry it with them to their jobs, when advocating, when speaking about the connection they have to the MHSA, the difference the MHSA makes, and how they know that the Commission is making that difference. She stated the ASR's primary role is to help tell the

story of how the Commission knows it is doing what it strives to do and that it is being done together. She reviewed the other purposes listed on the Results-Based Strategic Plan presentation slide.

Ms. Brutschy stated much will be accomplished quickly today by starting large and then going deeper and deeper. She asked Commissioners to keep their eyes on the results to ensure everyone is at the same level and that there is agreement.

Ms. Brutschy stated Lisa Colvig-Niclai will be listening today for ideas, patterns, and commonalities. She turned the microphone over to Lisa Colvig-Niclai to discuss how today's goals will be accomplished.

The Plan

Lisa Colvig-Niclai, Vice President of Evaluation, ASR, stated Chair Boyd's description of what drove him was getting to a place of a clear definition of successful outcomes. She asked what that looks like, what the metrics look like, and how to know that the Commission is doing the work that it was charged with. She reviewed the Our Understanding of Results logic model presentation slide that showed the most important buckets of the work, how to know it is working well, and to what end.

Ms. Colvig-Niclai stated the green Strategy bubbles graphic represents the buckets of the most important work, and the yellow Short-Term Result bubbles represent the operational results – in other words, how to know if the Commission is doing that work well. She stated it is not yet about the outcomes that are achieved for clients or the population – those are represented by the orange Longer-Term Result bubbles – but it is about the measures of effectiveness, if the Commission is doing that work well. The yellow bubble column will answer the questions of when the Commission will look at what it is doing and how well it is doing.

Ms. Colvig-Niclai stated the orange Longer-Term Result bubbles graphic is the big "so what?" She stated the Commission could be doing its work well, but to what end? The orange bubbles will contain the client and population measures that will be the beacon that all this work is aiming toward. Some of those are called out in the MHSA, such as a focus on school, criminal justice involvement, employment, homelessness, or suicide. She stated the need to create consensus around the community-level indicators to aim toward and monitor to ensure that they are moving gradually in California in the right direction.

Ms. Colvig-Niclai stated the ASR has an intensive nine-month process to fill in the Our Understanding of Results logic model framework. She turned the microphone over to Samantha Green to walk Commissioners through that process.

The Process

Samantha Green, Project Manager, ASR, reviewed the Strategic Plan Process Map Summary (Process Map) presentation slide, which denoted four phases laid out for this nine-month process. She stated hard copies of the Process Map are on each of the discussion tables.

Ms. Green reviewed each of the four phases of the Process Map:

- Phase 1 is the organizational roadmap. It will define who the Commission is. It will include personal interviews, the workshop later today, and an online survey to help the ASR identify themes and collect data.
    - Defines who the Commission is and identifies those buckets of most important work

- Clarifies the role, goals, and priorities of the Commission and develops that shared understanding that Commission Danovitch requested of why the Commission does what it does
- Considers the activities with the greatest potential to meet the goals and outcomes identified

- Phase 2 is the framework for success. These are operational measures.
  - Identifies how well the Commission is doing
  - Identifies how to know that the Commissioners' work is effective and moving toward the intended outcomes
  - Sets up a framework for understanding how success will be measured
- Phase 3 is the populated framework for success with baseline data to understand the starting point. It will ensure continued success. It will include another community survey, more discussions, and collecting additional information to understand the baseline of where the Commission is now based on those measures.
- Phase 4 is the final report. It will tell the story. It will bring all the gathered information together.
  - Identifies the shared priorities
  - Identifies a way of communicating that to individuals effectively
  - Includes the results and activities done to date
  - Sets the framework for the Commission to tell its story effectively from here on out
  - Allows the framework to be updated on a regular basis

Opportunities for Feedback

Ms. Brutschy stated the Commission information has already been inputted on a Tableau database and is ready to go. The icons on the Process Map let the ASR know if they met their markers for participation, check-in, relook, and organization. Commissioners will continue to see the Process Map throughout the strategic planning process.

Ms. Brutschy stated there are discussion questions on the back of the Process Map for Commissioners to make a note of their ideas so they will be ready for the afternoon break-out session. There are also note cards for comments to the ASR, and sticky notes for Commissioners to stick their comments to the beautiful charts at the back of the room that they feel strongly about.

Ms. Brutschy stated personal interviews will be conducted over the next two weeks. She asked Commissioners to sign up for personal interviews on the sign-up sheet. Also, an online survey with the same questions that are on the back of the Process Map will be posted online for additional feedback.

Commissioner Comments and Suggestions for the ASR to Consider

Chair Boyd welcomed Commissioner Brown and introduced him to Ms. Brutschy.

Ms. Brutschy provided a brief summary for Commissioner Brown on items he had missed including the Commissioner Introduction activity where Commissioners introduced themselves and shared their passion area.

[See Commissioner Brown's contribution in the Commissioner Introduction section, above.]

Ms. Brutschy asked Commissioners for comments and suggestions to consider as the ASR launches this process.

Commissioner Alvarez asked the ASR to consider individuals who may not be as familiar with the Commission but could benefit from the Commission's activities, and how to reach out to nontraditional partners in getting that input and ensuring that they can become engaged in the future.

Commissioner Anthony asked the ASR to include a statement about the Commission's purpose and what Commissioners see as that purpose.

Commissioner Brown stated his hope that the Commission can collectively come up with ideas and thoughts in terms of the direction of the Commission and the Commission's approach to this awesome responsibility that it has been entrusted with, and to work together to try to craft the best possible use of the considerable amount of funding that can do a considerable amount of good if done the right way.

Commissioner Gordon asked the ASR to consider that California is in an inflection point now. He suggested considering top-line things that Commissioners can agree on to get across to a new governor or individuals in the new administration when it is timely to do so, such as the top four things that need to be worked on, not exactly what to do but what should be paid attention to.

MHSOAC Framework

Executive Director Ewing provided an overview, with a slide presentation, of the mission statement, the components of the MHSA, the Commission's current portfolio, Commission activities, and the connection of those activities to each other. He also discussed missed opportunities within these activities. He noted that the Commission activities have been placed on posters in the back for reference throughout the day. He asked Commissioners to put concerns onto sticky notes and stick them to the appropriate posters.

Executive Director Ewing stated he wanted to put on the table all the functions that the staff do every day to remind Commissioners how they connect in some ways but also show where connections have been missed, and to remind Commissioners of functions that have not been revisited for some time such as plan review, which is a potentially important opportunity that the Commission has not discussed publicly.

Executive Director Ewing stated the strategic planning session was a good place to give Commissioners the full perspective of what is on staff's plate, to support Commissioner discussion around which of those functions staff needs to double down on and which of those functions might need to be transformed and reshaped. This is important so at the end of the strategic planning process, staff will have clear direction and guidance to be thoughtful with resources.

Commissioner Questions and Discussion

Commissioner Ashbeck stated it is important to underline the process of the work in all the activities that the Commission does. How the Commission does the work it does is the underlying piece of all the activities. She asked staff to help Commissioners have a better understanding of the Rules of Procedure.

Executive Director agreed that the Rules of Procedure need to be updated.

Chair Boyd agreed that Commissioners should better understand those rules to comply until a better process is put in place.

Commissioner Anthony stated she would like to be made aware of opportunities for Commissioners to participate within the Committee structure and which Commissioners are not participating in the Committee structure.

Chair Boyd stated Executive Director Ewing is the best person to try to meet the Commissioner's needs and sometimes that means taking on too much. The idea of creating a calendar and sending it out monthly to all Commissioners to identify points of engagement was identified at the beginning of this year but staff has been unable to get to it due to the workload of the Commission. He asked Commissioners to be sensitive to the workload of staff as objectives and priorities are set.

ASR Questions for Commissioners

Ms. Brutschy asked Commissioners to share their thoughts and ideas about the following questions in preparation for the group discussion later in the day.

Question #1: Given your broad view of mental health around the state of California, what is the unique role of the Commission in helping meet community mental health needs?

Commissioner Gordon stated the Commission is doing a lot of routine functions which are not unimportant but should not be the signature activities of the Commission. He stated the Commission is behind the MHSA when it was first passed in the following bulleted items:

- A unique role of the Commission is prompting innovation. Funding is given to counties but counties have no incentive to cooperate, collaborate, or share good practices – how do we get to a system which is doing things differently?
- The Commission does not know the results of its activities due to the lack of data. There are different agencies and they have different databases. They are reluctant to share data or cooperate in terms of how data gets put together and reported so the Commission is always scrambling to find out how activities are doing. It is the same thing in education and it is worse in health care.
- Leadership Development – is the Commission investing in leaders who will be innovative, who will be disrupters?
- The notion of wellness – how to get away from the notion of focusing on weakness or disability.

Commissioner Brown:

- The magnitude of what this small Commission is tasked with doing and is currently doing is overwhelming. The reality is that, without the proper structure and staff, it is almost an impossible task to do all of that and to do it well. The Commissioners need to ask in their role how to lead counties, consumers, and community-based organizations in figuring out a way to collaborate and work together on this very complex, longstanding, difficult issue of mental health in the communities.
- The Commission should be focused on shaping how counties spend their own dollars including their MHSA dollars and incentivize them to augment them with other funding. He suggested that a way to do that is to develop a report, similar to what the Criminal Justice Committee did. The report was a mechanism to get the attention of the governor and the Legislature to get some action in terms of additional funding.

- Although it is time-consuming and difficult, there is a need to look at these projects and come up with a written deliverable that can be given to those groups that ultimately will be responsible for the funding at the state level. These also will serve as a mechanism for policymakers at the local and county levels to see where there have been successes where individuals have come together and shared everything, including their budgets.

Commissioner Danovitch:

- He agreed with Chair Boyd's opening comments about timing around these issues.
- The MHSA is a unique Act inasmuch as it did something remarkable.
- It recognized that there were major problems across California in the way that mental health is provided and the way conditions are prevented.
- It established an audacious and bold aspiration to transform the mental health system – not just to make incremental improvements but to transform it.
- It created pathways, processes, the five broad strategies, and mechanisms such as innovation.
- The challenge is to work within that construct and to overcome some of the limitations of that construct to be true to that intent, and to do so in a state that is the sixth biggest national economy.
- The important subject of how to coordinate and integrate services is critical.

Commissioner Ashbeck:

- A unique role of the Commission is to do things that counties cannot do by themselves. What is the highest common denominator that the Commission can operate in?
- A unique role of the Commission is to build incentives and/or limit barriers to implementation of local programs.

Vice Chair Aslami-Tamplen stated the consumer movement has the five key concepts of recovery. She stated she was going to tie that to what the Commission can do in its unique role.

- Hope. Providing hope that recovery is possible, that people do get well, and that ways toward recovery can be found.
- Personal responsibility. What is the Commission's responsibility? Always be looking at that in terms of accountability and oversight. How is the Commission doing that with the projects, regulations, and innovations that are presented to Commissioners that do not seem innovative?
- Education. What kind of technical assistance is needed for counties and stakeholders around what is working and what is not working?
- Advocacy. This is critical. The Commission needs to continue to advocate with the governor, legislators, and amongst each other around the paths towards recovery. Many counties come to the Commission with great ideas and then they experience stigma and discrimination in their own local communities, specifically NIMBYism, or Not in My Backyard. Housing is a huge crisis in California but programs cannot be opened in communities because of the NIMBYism issue.

- Support. Supporting the Commission's vision, the work, and the counties to be successful, and the legislators to better understand the MHSA so that recovery is possible for mental health consumers and family members.

Chair Boyd stated he especially liked Commissioner Danovitch's frame, which is how to fully realize the opportunities, challenges, and limitations while staying true to the MHSA.

- What is needed at the local level for success where a lot of this work happens before it gets to the Commission – peers, elected officials, mental health board members, etc.
- The Commission can be a political cover. The Commission works in an environment where the County Board of Supervisors is able to exercise oversight around state funding and move dollars around and that inhibits counties at the local level from being as successful as they desire. The Commission can look at the county level. How this is done is essential in addressing the political issues.

Commissioner Anthony:

- Ensure that the Commission does not focus on the individual silos of each seat on the Commission. The focus should be on how the Commission can ensure positive outcomes for the individual and their family members who are living in the communities in counties and living with severe mental illnesses. That cannot be forgotten.

Commissioner Bunch:

- The Commission has a push to look for programs that are innovative, but should move more toward what communities and clients need versus what sounds cool. Individuals in skid row need housing. This is not innovative but it is needed.
- It is important for Commissioners to receive updates of the outcomes and impacts of approved plans. There is no visible evidence in the field of the millions of dollars that have been allocated.

Commissioner Alvarez:

- Think about the Commission's responsibility statewide to identify lessons learned from innovation projects, to not reinvent the wheel every time, and to continually ask what more can be done.
- Navigate the web of state agencies in order to not only be good stewards of the public dollar but also collectively as state agencies and Commissioners prioritize the mental health and wellbeing of families. The Commission is putting resources where other state agencies put resources but the entities do not communicate with each other. This does a disservice to the families that need the services in the first place.

Commissioner Madrigal-Weiss:

- One of the purposes of the MHSA is to decrease school failure due to the unmet mental health needs of children. The Commission is in a unique position to help define common language, standards, and metrics. What does the language used in mental health, schools, and juvenile justice look like? Agencies work for common goals but come at it differently.
- It is important for Commissioners to receive updates of the outcomes and impacts of approved plans for themselves and also so they can share examples with other states and entities of the results of the funding the Commission has allocated and the impact that Proposition 63 has made in the state of California.

Ms. Brutschy stated there is so much commonality among the Commissioners and agreement about the possibilities. She noted that amplification, elevation, and collaboration seem to be coming through. She asked Commissioners to share their thoughts and ideas on the second question in preparation for the group discussion later in the day.

Question #2: How would you know if the Commission is successful in fulfilling this role?

Commissioner Madrigal-Weiss:

- Intentionality. The systems would align with language, standards, and metrics. If the Commission worked toward this in mental health disciplines and schools, resources and funding could be leveraged to do something meaningful. Right now, it is hit and miss. Doing it with intention and having common metric standards to address prevention and intervention would lead to success.

Commissioner Alvarez:

- Impact of investment. Having data that demonstrates the effectiveness of the investments the Commission makes is a standard the Commission should hold itself to.
- Seeing a change in the numbers, particularly when it comes to access to services for underserved communities.
- Coordination. Having discussions and intentional strategic planning with the other agencies in this space to coordinate efforts and ensure the most impact.

Commissioner Bunch:

- More access and less unserved and underserved communities.

Commissioner Anthony:

- Coordination, wellbeing, and happiness. A way of measuring that persons who are diagnosed with serious mental illnesses are receiving coordinated services, living in recovery, living independently, and experiencing some level of happiness.

Chair Boyd:

- Alignment – and fast. Alignment with the governor's office, the DHCS, and counties that are supported by strong public engagement and driven in a rapid timeline that matches the urgency of the situation.

Vice Chair Aslami-Tamplen:

- Continuous improvement and an ability to adapt to changing environment and changing needs. Success does not just happen once; it requires an ongoing commitment. There are successes in one area but then another area will require attention and further strategic planning processes. Involvement of stakeholders in the process is imperative.

Commissioner Ashbeck:

- Alignment. If any one sector could have figured this out, they would have, but they cannot. The eight children's hospitals are meeting on Monday to discuss what they can collectively do. The power of that is amazing.
- Counties saying it is easier to do their work and it is making a difference. That is where the work is done. If counties describe that the process is easier and more individuals are being served, that would be a huge success.

Commissioner Danovitch:

- Dashboard. Achieve a state-level dashboard that reflects the mental health and health of California residents. It is difficult to change what cannot be measured. The Commission's work begins and ends with measurement.

Commissioner Brown:

- Facilitate enlightenment about mental illness and challenges and paths to solutions with legislators, communities, state county officials, CEOs, and communities.
- Quality of life. Assist counties to identify how they can best allocate resources, coordinate efforts, reduce stigma, and increase quality of life to mentally ill individuals, families, and the community at large.

Commissioner Gordon:

- Leadership. Importance of grooming leaders. The Commission can take a major role in prompting investment in grooming leaders locally and statewide because that is where sustainability of all of this will come from.
- Consumer representation. Success means that individuals do not have to pound on the Commission to ask to be listened to, but that the consumer voice is routinely included and valued as part of the way the Commission operates and does business.

Morning Session Closing Remarks

Ms. Brutschy stated the afternoon session will be dynamic. Participants will be in mixed groups to think more deeply about some of the questions and the solutions just offered.

Executive Director Ewing stated staff thinks about these issues every day. He agreed with Commissioner Brown about the way the criminal justice project drew attention. He stated it also is a way to get Commissioners in alignment on a topic. Rather than bringing bills before the Commission that someone else has written for debate, a lot of the work staff is trying to do is to give Commissioners a common framework for understanding what is in place today, what is working and not working, and hearing the Commissioners' common voice through the vote to adopt a report. This is important because staff is trying to do that today – to create shared understanding of where the Commission is in terms of how time and resources are used. The most important thing that staff has is Commissioners' time.

Executive Director Ewing stated he was delighted that the Commissioners were beginning to focus on big pieces but the hard part is how to do it. Many issues that were brought up are tough, enduring kinds of challenges around leadership, data, siloing of dollars, and responsibility, the fiscal incentives, and competitive cost avoidance – county agencies that are working hard not to have to care for that really expensive child or family but hoping someone else does it because of the expense. In the meantime, that child or family struggles, suffers, and loses. It is the examples of young children who are struggling with mental health needs in schools or the child welfare system or the juvenile justice system. The connections often are lost from the view of the public agency, but it is the parents, families, colleagues, and neighbors who have to try to help that child to integrate those services and, oftentimes, particularly for disenfranchised communities, they are the least equipped to do that.

Executive Director Ewing dismissed everyone for the lunch break.

LUNCH BREAK

STRATEGIC PLANNING WORKSHOP

Chair Boyd asked Ms. Brutschy to guide the Commission through the strategic planning workshop process.

Ms. Brutschy stated the participants will be randomly assigned to tables with two Commissioners and a scribe at each of five tables for the afternoon workshop of facilitated conversations. She asked for a show of hands of individuals in the audience who represent a county program, community-based program, consumer or family member, another type of stakeholder, Commission staff, or veterans to get an idea of who the participants were who would be joining in the workshop.

Ms. Brutschy stated each table will discuss the same two questions that the Commissioners were asked during the morning session: the unique role of the Commission and what success looks like for the Commission. She asked everyone to count off from one to five to divide up into five tables for the workshop discussions.

Ms. Brutschy dismissed everyone to go to their respective tables.

Strategic Planning Workshop Report-Out

Commissioners reconvened and Ms. Brutschy asked the table captains to summarize the feedback received during the workshop discussions. She stated her team will be looking for patterns.

Question #1

Table 1

Noah Hampton-Asmus, ACCESS California, Mental Health America of Northern California (NorCal MHA), summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Transparency and visibility between the Commission and the counties, between counties, and between counties and residents that would spread the work of the Commission and make it more visible
    - To promote the work in mental health
    - To build relationships in communities that might not know what everyone is doing between the different elements and areas.
- Inclusion and empowerment
    - To be a steward of the mission of the MHSA
    - To further the mission of the MHSA as a state role model of client and family-driven services and client and family-driven advocacy

Table 2

Richard Van Horn, Former Commissioner, Mental Health America of Los Angeles, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Describe the vision for mental health systems
- Megaphone for the most disenfranchised groups around the state

- Provide a statewide leadership role
- Tell the story
    - Be a serious presence in the media and the public voice

Table 3

Sharon Yates, National Alliance on Mental Illness (NAMI), LACC, & CFLC Committees, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Legislation
- Data Outcomes
- Broad Standards

Table 4

Theresa Comstock, President, California Association of Local Behavioral Health Boards and Commissions, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Be a change agent for transformational change
    - Encourage collaboration both within local communities and among state agencies
    - Identify best practices

Table 5

Jane Adcock, California Behavioral Health Planning Council, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Accountability should be at both the local and the system level
    - It is important for the Commission to communicate out and to provide transparency
- Scope of authority and limited resources to fulfill the scope
    - Since the Commission is spread thin, a review of the mandated versus discretionary activities would be useful
- Serve as a model for stakeholder engagement and collaboration
- Serve as a leader in innovation
    - Provide coordination, resources, and technical assistance
    - Bring expertise to bear
- Serve as a leader in promoting systems collaboration, coordination, and sharing of resources of behavioral health system with other systems such as physical health care, child welfare, juvenile criminal justice, and education

Question #2

Table 1

Noah Hampton-Asmus, ACCESS California, Mental Health America of Northern California (NorCal MHA), summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Accountability
  - Tracking attendance and engagement
  - Recognizing community voices
  - Attributing that this idea was heard in several different counties and we want to reinforce the positivity that had been received
- Oversight
  - Quality improvement process that is based on evaluations and the dissemination of learning and information that will lead to advocacy

Table 2

Richard Van Horn, Former Commissioner, Mental Health America of Los Angeles, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Transformation and disruption – collaborative efforts are transforming and disrupting the old system
- People know who the Commission is in the communities around the state
- Define the successful steps toward the north star or are successfully moving north in the northbound train

Table 3

Sharon Yates, National Alliance on Mental Illness (NAMI), LACC, & CFLC Committees, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Growth in the mental health workforce
- Getting the legislative bill signed
- Increasing accessibility of quality-appropriate services to all

Table 4

Theresa Comstock, President, California Association of Local Behavioral Health Boards and Commissions, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Transformation and outcomes – the Commission would be using data and performance measures to drive transformation change and inform programs and planning
- Stakeholders would be involved in community planning processes

- The Commission would understand good innovations from counties and from other states and countries
- The Commission would be able to identify best practices, which would be characteristics of programs that have best outcomes and could be implemented with good fidelity

Table 5

Jane Adcock, California Behavioral Health Planning Council, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- California would continue to be the leader for the nation
- Persons with serious mental illness are receiving coordinated services
- They are in recovery
- They are safely housed
- Policymakers are informed, resulting in well-designed programs and effective use of resources
- The public is educated and it reaches a level of enlightenment regarding stigma and NIMBY or Not In My Backyard
- The Commission helps the systems to truly work together, combining resources to increase success and using data to track the reductions in hospitalizations, suicides, school dropout, child welfare, engagement, etc.
- Stakeholders would be satisfied and happy and would feel that they were heard and the processes would reflect their input
- Data, information, and reports would be available to inform all regarding the funding, who was served, successful programs, and unmet needs, gaps, and services, etc.

Bundling Report-Out

Ms. Brutschy stated there was a lot of commonality, not only in what the role could be, particularly about Commissioners knowing what their role was and being able to communicate. With success, the focus on oversight and accountability was key. Ms. Brutschy turned the microphone over to Ms. Colvig-Niclai to provide a bundling report of the feedback gathered from the strategic planning workshop discussions.

Bundling of Question #1 Responses

Ms. Colvig-Niclai stated there were several things related to accountability:

- Collecting data
- Setting standards
- Monitoring standards
- Helping tell the story
- Being a model for stakeholder engagement
- Modeling inclusion and empowerment
- Being a visionary

- Being a leader in innovation
- Being a change agent for transformational change
- Being a leader
- Focusing on priorities
- Being a convener
- Helping to stimulate systems collaboration and coordination
- Minding legislation
- Being an advocate or being a megaphone
- Promoting transparency and visibility between partners and families, partners and the Commission, etc.

Bundling of Question #2 Responses

Ms. Colvig-Niclai stated there were many things that came out as markers of success:

- Legislative bills are signed
- California is a leader in mental health
- Informed policymakers
- People around the state would know who the Commission is
- The public is educated around mental health
    - Social awareness around the work of the Commission and the importance of mental health and mental wellness
- Service Delivery
    - Accessibility to services
    - Better coordinated services
    - Increased wellness
    - Increased mental health workforce
- Collaboration between partners
- Being a part of transformation and disruptive change
- Using data to track outcomes and change and share that story
- Stakeholder satisfaction, engagement, happiness, and being involved in the work
- Oversight and advocacy
    - Information being available or promoting information, sharing it out in terms of best practices
    - Keeping eyes on what is happening and being learned, and sharing, promoting, and advocating for the practices that work

Ms. Brutschy added that she heard groups discussing as a marker of success that the Commission would be visible so that people would really know and see a difference in the

communities and the neighborhoods that they lived and worked in. That is powerful. She stated happiness and wellbeing as a marker of success is important. Wellbeing for all is attainable in the state of California.

Closing Statements

Ms. Brutschy thanked everyone for their participation. She stated this process was very helpful to the ASR team. She stated there will be many opportunities to further explore these issues. She stated the ASR will be coming back to the Commission to try the bundling and narrowing on for size at the November Commission meeting. The online survey will be posted on the website and through the LISTSERV. It is important now to go broad. Some of these same themes and questions will be included in the first online survey.

Ms. Brutschy thanked Commissioners in advance for participating in personal interviews. She suggested that Commissioners go out and collect information to funnel to the ASR about the role that is unique to this Commission and how the Commission can tell the story of its success. She stated the goal of completing the communication, roadmap, and data portions of the strategic planning process by May of 2019.

Commissioner Ashbeck and Vice Chair Aslami-Tamplen thanked the ASR team for their help and thanked everyone for their participation.

On behalf of the Commission, Executive Director Ewing thanked everyone for their participation. He stated much of the process has been built in through this meeting, the November Commission meeting, personal interviews, the survey, and public engagement opportunities. He asked everyone to let staff know if there are additional ways to capture more voices and vision in terms of the role of the Commission. The more robust this process is, the more likely staff can put in front of Commissioners the grist that they need to frame out opportunities that the Commission has and how to move forward. He reiterated the importance of letting staff know if there is a piece of the process that can be enhanced.

GENERAL PUBLIC COMMENT

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, stated appreciation of beginning the meeting with Commissioner introductions. It is helpful for the community to understand the perspective each Commissioner comes to the table with.

Poshi Walker, LGBTQ Program Director, NorCal MHA, Co-Director, Out 4 Mental Health, loved the Commissioner introductions and thought the whole day was fabulous. The speaker noted that many staff members are starting to put preferred pronouns on emails, which is fabulous, but there are a number of people who are still uncomfortable and unsure what to do with that. The speaker offered that Out 4 Mental Health has a quick training on pronouns that also is followed up with a fact sheet. The speaker suggested presenting this information at a future Commission meeting so individuals can better understand, get used to saying their pronouns, and make a safe space for queer and trans people.

Steve Leoni, consumer and advocate, stated this was a wonderful day. The Commission is the embodiment of the MHSA in terms of moving forward. Individuals, including the speaker, who worked on the original MHSA had hopes and dreams about a better mental health community in the state. The Commission is the carrier of that vision. One of the things that many of the stakeholders who identify with that idea always wanted was a meeting where the boundaries were down, where the Commission and the community members could talk in a large group –

and, for the most part, they did not get it. Today was a fulfillment of part of that role of being the custodians of the vision of the MHSA. He thanked the Commission.

Noah Hampton-Asmus, ACCESS California, NorCal MHA, stated today's afternoon session provided the opportunity to do something that was lost in reporting and evaluation – to take qualitative information. Moving forward with evaluation, the qualitative aspects of mental health are measured because it is about feeling better and about making people feel independent and resilient. This was a foundational principal of how to get qualitative information and how important it is to the process moving forward. It was well done.

RECESS

Vice Chair Aslami-Tamplen recessed the meeting at 3:16 p.m. and invited everyone to join the Commission for Day 2 of the meeting tomorrow morning at 9:00 a.m.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplen
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
September 27, 2018

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

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Senator Jim Beall

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

DAY 2: September 27, 2018

RECONVENE AND WELCOME

Chair John Boyd reconvened 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 and stated he moved a few agenda items up. He gave a brief summary of yesterday's Strategic Planning Session.

Chair Boyd welcomed Assemblymember Wendy Carrillo to the Commission. Commissioner Carrillo introduced herself.

Youth Participation

The Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Amanda Southworth introduced herself.

Consumer/Family Voice

Chair Boyd stated the scheduled speaker was unable to be in attendance. He stated the next Commission meeting will begin with an individual with lived experience sharing their story.

Chair's Remarks

Chair Boyd asked Ms. Yeroshek to direct the public where to access the expenditures for all levels of the Commission for the last two years. Ms. Yeroshek stated the Commission's expenditures are on the website for the State Controller's Office.

Chair Boyd asked about the process for next month's nominations for chair and vice chair for 2019. Ms. Yeroshek stated there will be nominations at the next Commission meeting. The individuals nominated will be given an opportunity to say a few words.

Chair Boyd paused for a moment to acknowledge suicide prevention month and all the young people who have been impacted by suicide. He also acknowledged the role that sexual assault has in the area of trauma, post-traumatic stress, and suicide.

ACTION

1: Approve August 23, 2018, MHSOAC Meeting Minutes

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

The Commission approves the August 23, 2018, Meeting Minutes.

Motion carried 10 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Ashbeck, Brown, and Bunch.

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

Ahmad Bahrami, Program Manager, Kings County Behavioral Health, provided an overview, with a slide presentation, of the problem, innovative components, learning goals, evaluation, and sustainability of the proposed Multiple Organization Shared Telepsychiatry Innovation project.

Commissioner Questions and Discussion

Commissioner Alvarez asked how the county planned to introduce this concept to patients, families, and peer support teams to ensure success of the project.

Mr. Bahrami stated county residents are already familiar with telepsychiatry services. The project will shorten the length between appointments from approximately five weeks to five to seven days.

Commissioner Danovitch asked what the current barriers are to implementing this program.

Mr. Bahrami stated the startup cost is a barrier because most providers are small. Current telepsychiatry services are with one provider. Having an approved plan would also increase support from the county administration.

Commissioner Danovitch stated his concern about whether the learnings from the proposed project are predicated on being able to compare this intervention to another comparison group. That would require a level of study that is sophisticated and challenging to do and it may be difficult at the end of this to make a comparison that allows an informed decision about whether to continue it. He asked if there were other learnings from this that inform decisions about whether to sustain it.

Vice Chair Aslami-Tamplen stated she would have liked to have seen full-time peer positions since that is the driving force of this Innovation. She asked if the peers will be trained in things that are developed by consumers, such as the Wellness Recovery Action Plan (WRAP). She stated she hoped the collaborations between the psychiatrists and peers will decrease stigma.

Mr. Bahrami stated the first phase will allow the county to do the necessary classification and position studies for the new peer positions while peers can get started in the projects by doing contract work. Peers will go through trainings that other staff already go through on wellness and recovery and the WRAP program.

Commissioner Anthony suggested that the county consider agency perceptions and predisposed biases when doing the study and if changes can be made to improve those.

Commissioner Bunch stated the amount requested is below the projected cost of the program. She asked why the county did not ask for more funding.

Mr. Bahrami stated that is the way Innovation funding is set up with each county receiving a certain amount. Funding will also be leveraged through Medi-Cal and Community Services and Supports (CSS).

Commissioner Wooton stated her concern that the county is relying on Senate Bill (AB) 906, peer support specialist certification, for peers. She encouraged the county to look at other counties and their peer certification curriculum.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the proposed project.

Ken Baird spoke in support of the proposed project.

Poshi Walker, LGBTQ Program Director, Mental Health American of Northern California (NorCal MHA), Co-Director, Out 4 Mental Health, spoke in support of the proposed project. The speaker agreed with Vice Chair Aslami-Tamplen that the peer support specialists should be full-time, that there should be more than two, that they should have a supervisor who is also a peer, and that they should be in a safe environment. The speaker stated the need to look for

happiness, not just to reduce symptoms, and for medications that not only reduce symptoms but that cause the least amount of harm. The speaker supported the comments that would be made by the next speaker, Mandy Taylor.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, spoke in support of the proposed project. The speaker encouraged the county to ensure that their providers are trained in providing clinical care to their transgender and LGB clients so that more harm is not being done by their psychiatry then help.

Max Geide, County Behavioral Health Directors Association (CBHDA), spoke in support of the proposed project.

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

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

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

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

ACTION

3: <u>Los Angeles County Innovation Plans (2)</u>

Presenters for Conservatees Living in the Community Project:

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

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

<u>Conservatees Living in the Community Project</u>

Debbie Innes-Gomberg, Deputy Director, Los Angeles County, provided an overview, with a slide presentation, of the problem, innovative components, and learning questions and outcomes of the proposed Conservatees Living in the Community Innovation project.

Maurnie Edwards, Health Program Analyst, Los Angeles County, spoke about the need for and benefits from the peer support component of the proposed Innovation project.

Evelio Franco, Team Supervisor, Los Angeles County, discussed how consumers and family members will benefit from the proposed Innovation project.

Connie Draxler, Los Angeles Public Guardian, discussed the innovative team environment component of the proposed Innovation project.

Commissioner Questions and Discussion

Commissioner Wooton asked the county to return to share the findings of this project. Peer support is an evidence-based practice but it is not done much in California.

Commissioner Danovitch questioned the sustainability of the proposed project. A significant portion of durable goods will depreciate over the length of the project. He asked about the number of clients who will be served by the proposed project.

Dr. Innes-Gomberg stated each of the 16 teams will serve approximately 50 clients at any one particular time. She stated, if the project is successful and the county learns the best practices associated with the skill-building, increasing decisional capacity, the role of the peers in that process, and how it is tied to the outpatient mental health program, it will be funded with a combination of CSS Systems Development and Full Service Partnership (FSP) funding.

Vice Chair Aslami-Tamplen asked if the proposed project will help with the individuals whom the public guardians have already served or if it will add more individuals.

Ms. Draxler stated it will be both. Individuals who do not qualify for an FSP program will be eligible for this enhanced service. Individuals will be brought out of Institutions for Mental Disease (IMDs) or other higher levels of care to lower levels of care because of this enhanced service.

Vice Chair Aslami-Tamplen stated her concern that the peers may be coopted into doing what the conservators are doing instead of doing the peer work.

Dr. Innes-Gomberg stated recovery-oriented services must be provided in order to increase conservatorship capacity and peers are critically important to that.

Commissioner Mitchell asked about the phrase “increase conservatorship capacity” and if it refers to the number of individuals served.

Dr. Innes-Gomberg stated there is a parallel to increasing access to mental health services and providing the optimal frequency and intensity of services so individuals get better and can exit the system.

Commissioner Mitchell asked how many individuals in the county are conserved and how many have become un-conserved.

Ms. Drexler stated there is an average of approximately 2,700 conservatees on any given day. The county receives approximately 100 referrals per month from acute psychiatric facilities and 60 to 70 percent are placed in a conservatorship. Getting off conservatorship varies from month to month.

<u>Therapeutic Transport Project</u>

Dr. Innes-Gomberg provided an overview, with a slide presentation, of the problem and innovative components of the proposed Therapeutic Transport Innovation project.

Anthony Ruffin, Outreach Worker, Los Angeles County, discussed the current process and how the proposed Innovation project will improve the process to better support consumers.

Paul Stansbury, Family Member, shared his experience of noise, chaos, and confusion of the current process during his son's psychotic episode that added stress for his son and disturbed his neighbors. He stated the need for a more dignified, humane treatment during this traumatic moment in his son's life. He stated law enforcement is doing better, but a peer would have provided calm understanding and would have better communicated to his son the steps being taken to help him.

Miriam Brown, Mental Health Clinical Program Manager, Los Angeles County Department of Mental Health, discussed the advantages of implementing the proposed project.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen stated, if the peer is driving, they are not really connecting.

Dr. Innes-Gomberg stated the county does not envision the peer driving.

Commissioner Wooton suggested something on the side of the van other than Los Angeles Mental Health to reduce stigma. She stated her concern about the wage amount for peers and whether they can live on that in Los Angeles County.

Dr. Innes-Gomberg stated the Department is currently in negotiations on that issue.

Commissioner Gordon asked about the phrase "those deemed safe for transport." He asked how that decision is made and what the backup is if there is an unanticipated problem in one of the vans.

Ms. Brown stated there is a policy in place in terms of whom to transport. Eventually there will also be protocols on how to make the decision of when a person will be safe to be transported. In an emergency, the clinicians on the scene would decide whether an alternative van is called or if an individual requires restraining.

Amanda Southworth asked if the county is going to scale to address the issue of transporting combative individuals or individuals who may be agitated or violent.

Dr. Innes-Gomberg stated the Department's goal is to use the proposed approach where possible.

Commissioner Anthony asked if the response time for the van will be included in the learning outcomes. She asked for more detail on how service delivery for the van will be evaluated.

Dr. Innes-Gomberg stated response time will be added to the metrics. In response to the question on service delivery, Dr. Innes-Gomberg stated that question is part of the learning questions and evaluation. She reviewed the presentation slide she had yet to discuss about the learning questions and evaluation.

Commissioner Anthony asked how often the manager and team will debrief and discuss the activities and services being provided.

Ms. Brown stated the teams will meet twice a day in the beginning, to discuss the plan for the day in the morning and the lessons learned and how to improve at the end of the day.

Commissioner Mitchell asked how the vans will answer emergency calls quicker than the historical emergency response vehicles in the same Los Angeles traffic.

Ms. Brown stated the vans will be located in specific areas throughout the county such as the county hospitals. She stated the team will collaborate with other emergency response teams to determine the quickest response during high-traffic situations.

Commissioner Alvarez asked about the differences between the proposed Innovation project and the references to other initiatives in Los Angeles that do similar work to minimize law enforcement involvement and to support the community.

Ms. Brown stated there is a collaborative with 39 of the 46 police departments in Los Angeles County to provide 40-hour training for all incoming law enforcement officers. The goal is for law enforcement and clinicians to work together. A 16-hour training has been developed for small police departments that cannot afford to put their officers through the 40-hour training. Over 5,000 law enforcement officers have been trained about law enforcement and mental health. Also, clinicians receive training about the policies and procedures of law enforcement.

Commissioner Alvarez asked if the team is expected to work on the back end when a call is received to determine which team is deployed to be more responsive and accurately respond to the needs of the individual. Ms. Brown stated they do.

Commissioner Alvarez asked about the key difference between their project and Alameda County's project.

Dr. Innes-Gomberg stated Alameda County does not have a peer component and they had a second component that was very different. She stated her team felt it was significantly different in terms of its goals and the overall approach.

Commissioner Madrigal-Weiss stated there is a statewide concern about how to address the issue with students not wanting to receive help because schools often do not respond immediately but only call 911 when all else fails. She asked if schools were part of the community planning process and, if so, if there was consideration to approach this to schools, if there already was a program in place, and, if so, how to learn more about it.

Dr. Innes-Gomberg stated the Department is working with LAUSD in a broad way to increase the Department's presence on campus. She stated the Innovation Pipeline Work Group was part of the community planning process but she was unsure if schools were a part of that.

Ms. Brown stated the Department works closely with schools. Schools call the Department directly. The only time they use 911 is when there is high need.

Public Comment

Max Geide spoke in support of both proposed projects.

Adrienne Shilton, Government Affairs Director, Steinberg Institute, spoke in support of both proposed projects.

Carmen Diaz, former Commissioner, spoke in support of both proposed projects.

Steve Leoni, consumer and advocate, spoke in support of both proposed projects but was concerned about how they would be implemented. He stated concern about the language for resources for the conservatees that would be marshalled "in the best interest of the client." He stated many sins have been committed under those words. He asked who determines what is in the best interest. He asked when someone will look at how to fix the 5150 process so that clients are no longer traumatized and retraumatized and so that clients can go to a place to feel better rather than a place they have to fear.

Noah Hampton-Asmus, ACCESS California, NorCal MHA, spoke in support of both proposed projects.

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

The MHSOAC approves Los Angeles County's Innovation Plan 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

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

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

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

The MHSOAC approves Los Angeles County's Innovation Plan as follows.

Name: Therapeutic Transportation

Amount: $18,342,400

Project Length: Three (3) years

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

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

Commissioner Bunch rejoined the Commissioners at the dais.

[Note: Agenda Item 4 was moved from after the lunch break to before the lunch break.]

Commissioner Gordon stated he needed to leave prior to Agenda Item 7, the naming of the fellowships. He went on record to give his support of naming the fellowships in honor of the two nominated individuals.

INFORMATION

4: Executive Director Report Out

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

Executive Director Ewing presented his report as follows:

Fiscal Oversight

Four to six counties seem to have spent Innovation funds without Commission approval. In some instances, it looks as if these were projects that were approved by the counties during a point in time when the Commission's approval was not required. The spending patterns were not consistent with the Commission's rules at certain points in time. We are still investigating this issue and will know more as counties submit their fiscal reports.

Innovation Incubator

An additional public forum is planned to discuss the consultant's report. The consultant has advised the Commission to clarify expectations for county Innovation plans. This will create an opportunity for a consent calendar, to explore opportunities to form an information clearinghouse and a learning community to support all aspects of the mental health system. The Innovation Incubator can serve as a venue for engaging counties in strategic opportunities for innovation, provide technical assistance, support evaluation, and disseminate the results.

Legislation

The Governor has signed the following bills:

- SB 192 (Beall) Mental Health Services Fund
- SB 688 (Moorlach) Mental Health Services Act: revenue and expenditure reports
- SB 1113 (Monning) Mental Health in the Workplace: voluntary standards

The Commission needs to consider the kinds of proposals it has already supported through policy recommendations and how to make those happen through legislation and budget change opportunities. Executive Director Ewing asked if there were legislative priorities or budget issues that Commissioners would like to bring up because this is the time that the legislative process will start to engage on that.

Commissioner Feedback

Vice Chair Aslami-Tamplen suggested cleaning up the stigmatizing language in the statutes, such as "mentally disordered offender."

Executive Director Ewing stated staff will work with the Chair and Vice Chair to work on this, possibly through one of the Committees, to consider the need for a historical update of the statutory references and the way individuals with mental health needs are characterized and spoken of.

Commissioner Anthony cautioned that changing the language may lessen the intent of those that the funding was intended to serve. A clinical definition of a service group should not be watered down so that it is no longer focused on who the law was intended to serve.

Commissioner Alvarez stated Assembly Bill (AB) 2315, pupil health: mental and behavioral health services was also signed by the Governor. She suggested exploring how mental health services can be more accessible to children in schools. Commission Gordon echoed this idea.

Vice Chair Aslami-Tamplen suggested legislation on the NIMBYism or Not in My Backyard issue specifically to increase peer respites.

Commissioner Wooton stated sometimes referrals are not made to peer respites because there is not a clinician onboard. She stated the hope that there will be training to the staff on the value of peer respites and programs being led by peers.

Commissioner Mitchell stated there is an issue with transition age youth (TAY) with mental health issues who are adults but do not function as adults. This is a parental concern.

Commissioner Alvarez stated there is a direct link between mental health and civic engagement. She asked the Commission to explore that moving forward.

Mental Health Policy Fellowship

An application has been posted on the website for individuals who want to serve on the advisory committee to help frame out the fellowship.

Stakeholder Contracts

Community meetings were held in San Diego and Los Angeles to look at how to allocate stakeholder advocacy dollars for the immigrant and refugee populations.

Staff has been in discussions with the Council on Criminal Justice and Behavioral Health about how to support them in their use of the criminal justice stakeholder advocacy dollars.

Triage Grants

The triage funds were reduced by 71 percent over what was initially proposed. Twenty-two of the twenty-four contracts have gone out to counties.

Butte County rejected the funds because they could not make up the shortfall. Those funds were reallocated to a different project that had been partially funded with the intent of fully spending the dollars that were allocated based on the scoring that was done through the application process.

Workplace Mental Health

Staff is in the process of bringing together advisors to help frame this project out.

Youth Innovation Project

Youth engagement meetings were convened in Northern California and the Central Valley to get feedback and input on the proposal. Staff is working to engage a consultant to help inform the youth leadership advisory body, to support youth engagement efforts, and to identify key challenges.

Commission Meeting Calendar

The October 25th meeting will be at the Marina Inn in Alameda County.

The November 14-15 (2-day) meeting will be at the Mission Inn in Riverside. The Commission meeting will be on Wednesday, November 14th and the strategic planning session will be on Thursday, November 15th.

There will be no Commission meeting in December.

Commissioner Questions and Discussion

Commissioner Alvarez asked staff to send Commissioners a weekly calendar of events so Commissioners can be part of the ongoing discussions.

Commissioner Alvarez stated she received positive feedback about the listening session in Los Angeles but the negative feedback was that no Commissioners were present. Commissioners add value to the conversation because they are part of discussions that no one else is part of and can share what they learn out in the community with staff and each other. Commissioners and staff would be more aligned with the needs of communities by sharing information.

Chair Boyd suggested adding a permanent 30-minute block in Commission meetings following the Executive Director Report Out for Commissioners to have dialogue amongst themselves on strategy, the direction of the Commission, and other priorities that are important to the Commission.

Commissioner Anthony agreed.

Commissioner Gordon agreed with the caveat to be respectful to staff because there is already a lot on their plate. He suggested figuring out how to complete current projects in a more coordinated way.

Chair Boyd asked staff to send the last three years' Commission meeting attendance sheets to Commissioners.

Chair Boyd reminded Commissioners that staff will be sending out the protocols on nominating and electing the chair and vice chair of the Commission for 2019 for next month's meeting.

Vice Chair Aslami-Tamplen stated Commissioner Ashbeck had expressed an interest in running for vice chair.

Commissioner Anthony asked about the nomination process. Ms. Yeroshek reviewed the process.

Public Comment

Stacie Hiramoto spoke in support of Chair Boyd's recommendation for a permanent 30-minute block for Commissioner discussion following the Executive Director Report Out. She reminded the Commission of a letter sent from many organizations encouraging the Commission to create a Legislative Committee so the public can have a more thoughtful, planned discussion on legislation.

Stacie Hiramoto requested two General Public Comment sections in the meeting agenda. She stated REMHDCO supports Sally Zinman as the name for the consumer fellowship and strongly recommends Rusty Selix for the professional fellowship name.

LUNCH BREAK

ACTION

5: <u>Santa Barbara County Innovation Plan Extension</u>

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

Commissioners Brown and Wooton recused themselves from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Lindsay Walter, J.D., Deputy Director of Operations and Administration, Santa Barbara County, requested a two-year extension on the Resiliency Interventions for Sexual Exploitation (RISE) Innovation project, which the Commission approved three years ago. She provided an overview of the background of the RISE Project.

Lisa Conn Akoni, MA, Marriage and Family Therapist, Santa Barbara County, discussed the need for the RISE Project in Santa Barbara County.

Carissa Phelps, J.D., CEO of Runaway Girl, Inc. provided an overview, with a slide presentation, of the status, goals met to date, and goals yet to be realized from the RISE Project. She stated the first three years were about collaboration and building the infrastructure.

Commissioner Questions and Discussion

Commissioner Danovitch asked about the achievements the program has been able to register in the first phase to understand the barriers. He asked what was successful in the first phase to help the success of the second phase.

Commissioner Bunch asked how the county partners with law enforcement.

Ms. Akoni reviewed the goals met to date on the goals met/goals yet to be realized presentation slide.

Commissioner Danovitch asked what would happen to the project if the extension was not funded.

Ms. Walter stated the county is trying to figure out how to develop this special population treatment into the TAY FSP and how to leverage Medi-Cal using the FSP model. The county now has leveraging partners – the Junior League has raised money to develop a safe house and the Good Samaritans received a grant last week to house individuals.

Commissioner Mitchell asked for a description of what a typical day's work is like.

Ms. Akoni stated she typically has 180 emails asking for support on a myriad of issues. There may be a schedule and then something else comes in. It is all day, every day. She stated the county is flying the plane while building it. The majority of her work is about the multidisciplinary treatment team.

Ms. Phelps provided the Commissioners with a survivor's perspective of the project and that the project feels warm, welcoming, accessible, and safe.

Public Comment

Max Geide spoke in support of the proposed project extension.

Poshi Walker spoke in support of the proposed project extension and suggested that housing discussions consider gender identity.

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

The MHSOAC approves Santa Barbara County's innovation project extension as follows:

Name: Resiliency Interventions for Sexual Exploitation (RISE)

Amount: $2,600,000 for a total INN project budget of $5,107,749

Project Length: Two (2) years for a total project duration of 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, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

Commissioners Brown and Wooton rejoined the Commissioners at the dais.

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, Ph.D., Associate Professor, Department of Medicine, University of California, Irvine

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

Karin Kalk, Tech Suite Project Manager, provided an overview, with a slide presentation, of the Tech Suite Project and lessons learned and introduced the Cohort #2 counties and their proposals. She played videos showcasing stakeholders who were involved in the community planning process speaking in support of the proposed project.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services, continued the slide presentation and discussed the Cohort #1 progress.

Dara H. Sorkin, Ph.D., Associate Professor, Department of Medicine, University of California, Irvine, continued the slide presentation and discussed the evaluation approach.

Imo Momoh, M.P.A., Director, Mental Health Services Act, San Francisco County Department of Public Health, continued the slide presentation and discussed the Cohort #2 San Francisco County Project.

Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire, continued the slide presentation and discussed the Cohort #2 Riverside County Project.

Ms. Kalk, continued the slide presentation and discussed the remaining counties in Cohort #2.

Commissioner Questions

Commissioner Danovitch asked if there is an execution risk and if the project can be harmed by the scaling before there is readiness to scale.

Dr. Ishikawa stated it is framed more that, instead of ten buildings being built simultaneously, additional individuals are coming to help construct the building that already has a set foundation. These individuals can bring added focus, perspective, and expertise to help make it more functional.

Ms. Kalk stated the collaborative process is one that fosters parallel learning. She gave the example of two counties working hard on one issue. It does not burden the other counties, but, as that learning emerges, it can be rapidly disseminated throughout the other counties to make them more effective. Collaborative learning is a structure that allows parallel learning where there is a common aim but distinction within each entity.

Commissioner Danovitch asked if 7 Cups and Mindstrong are for profit and, if so, how to ensure that there is alignment of interests of the individuals that are intended to be serve and the companies involved helping to provide the services.

Ms. Kalk stated there is a contract monitoring process that clearly describes the services and requirements of the project in the procurement and contractual process to ensure that every county's interests are translated into work orders to those vendors to ensure that there is delivery of those orders.

Commissioner Danovitch stated there will be repositories of incredibly sensitive information for large cohorts of individuals. There are a lot of unknowns in the positive sense but also in the risk sense in terms of how interaction with these applications will develop over time and where this is all going to go.

Ms. Kalk introduced Ann Collentine, Deputy Director of Programs, California Mental Health Services Authority (CalMHSA), and asked her to address Commissioner Danovitch's concern. Ms. Collentine stated technology and legal experts have been engaged to protect the rights of counties moving forward. These experts will continue to be engaged throughout the process.

Vice Chair Aslami-Tamplen stated concern about security, where collected information will be kept, and the $59 million that has already been invested in this collaborative with nothing yet to show for it.

Dr. Sorkin stated what happens to that data is critically important. Issues of privacy and security of the data are taken seriously. One of the key innovations that is happening here is that it is not likely that counties will ever be able to develop mobile apps within their county systems and counties will always need to reach out to private companies or universities. That process of bringing those apps into county mental health services is the innovation of this time. Working out the details of who gets access to what data and who is responsible for securing that is a large part of the work being done with the proposed project.

Mark Elson, Ph.D., Principal, Intrepid Ascent, stated Intrepid Ascent works with CalMHSA on privacy and security. Trust is the greatest asset for the organizations collaborating on this project and maintaining the trust of stakeholders. As with health care, there has been a shift to different cloud-hosted applications.

Dr. Elson stated Intrepid Ascent did a review of the initial two vendors, which informed the contracting process between CalMHSA and those vendors. Requirements from CalMHSA and specific county concerns are in those contracts. The collaborative not only has more collective expertise for this group contracting but also more leverage with these technology companies than if a county was individually contracting with an app vendor.

Dr. Elson stated the two vendors have been responsive and made changes to their privacy policy, are making movements toward greater transparency, and are working with counties on specific processes for informed consent.

Amanda Southworth stated everything that these counties are coming up with can be found outside the counties. The proposed project is not innovative enough to be considered groundbreaking. She stated she wished there was more brevity, security, and detail about what is happening with the proposed project and what the county wants to see from the results. It needs to be accessible to more individuals.

Commissioner Anthony stated she was involved in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN), the social services benefit-issuance system for 18 counties. She stated it was a monster when looking at implementation within each

of the counties. She asked about the dedication in each county for staff to meet and collaborate on a regular basis. She also asked about the methodology for distributing the information back to general county employees. Information going back for implementation and referral is the critical mass issue.

Ms. Kalk spoke about how the work is done across counties. There are mechanisms for routine shared learning, for example, telephone and online meetings and regular convenings. The intention of the collaborative is to overcome challenges more quickly and robustly because of the different perspectives. One-on-one support with counties is also maintained to keep the focus on local conditions.

Dr. Ishikawa spoke about how the work is done within counties. She stated Orange County has a team within the Innovation Office that interfaces with the collaborative multiple times a day, three to four days per week, tackling issues related to the development and implementation of the proposed project.

Commissioner Anthony asked about the full-time equivalent (FTE) staff who are contributing to this process on a monthly basis.

Dr. Ishikawa approximated a minimum of four FTE.

Chair Boyd asked Tom Insel, who presented at the July Commission meeting, to comment.

Tom Insel, M.D., Co-founder, Mindstrong Health, Advisor, 7 Cups, introduced himself and gave a brief overview of the background of Mindstrong Health. He responded to Commissioner Danovitch's questions about execution costs and whether this is the right time. He likened the project to CalMHSA's building a restaurant where Mindstrong and 7 Cups are the cooks to build things that can go onto a menu. He stated the questions are what is on that menu and how long and how big the menu should be. He stated the proposed project has been a spectacular opportunity for Mindstrong and 7 Cups to align with what the counties need. He stated this is a chance to create tools for the public good.

Commissioner Mitchell stated sometimes counties do not know what they want. She stated it would help Commissioners feel more comfortable if counties would demonstrate how the project is moving and growing each time expansion is requested. She stated it is difficult to approve additional funding when Commissioners do not know what was done with the first set of funds.

Betsy Gowan, Director, Tehama County Mental Health, stated the proposed project makes county mental health relevant to consumers in the community. Having county behavioral health associated with the project is huge. She also stated she has not seen as much excitement as when this idea was first broached, and the excitement continues to today. This gives county mental health an opportunity to provide input.

David Schoelen, Mental Health Services Act Administrator, Riverside County, asked the Commission to consider not only the technological innovation that these applications provide, but also the process innovations of county collaboration and reaching individuals who otherwise would not come to the table.

Commissioner Madrigal-Weiss stated the greatest struggle she is having is that the $59 million has already been invested but the proposed project is still at the learning level. It is important to show the Commission something that has been learned before asking for another $43 million. She asked if more counties are anticipated to come onboard after this group.

Ms. Kalk stated there is interest but it has not been entertained at this stage.

Commissioner Alvarez stated there is no question that the Commission is excited and believes in the promise of technology to do better by individuals with mental illness in order to promote mental health and wellbeing. She stated Commissioners want to ensure that the public dollars are best utilized, are tracked appropriately, and provide the return on the investment that is expected, that there is a sustainability plan, that there are lessons learned that are lifted up, and that there is ethical practice and privacy. That is the concern. She stated she has heard presentations on the Tech Suite project three times but still does not know what it does, what the impacts will be, and how these tools are identified to best meet the needs of priority populations in the counties.

Commissioner Brown addressed concerns of his fellow Commissioners:

Funding Concerns

- Much of the prior approval amount of $59 million was for two counties – Los Angeles County and Orange County. Those counties will get the larger chunks of innovation funding anyway. It is their money that has been allocated towards them.
- In the first cohort, there were three smaller counties that have piggybacked on those two larger counties and been able to get innovative technology that they would have had no chance of getting on their own for the amounts that they would have been allocated.
- The additional $42,868,480 involves eight additional counties and four cities. One of the eight additional counties is Riverside, which is another one of the four big counties in California. Of the $42 million, $25 million belongs to Riverside County.

Security Concerns

- Law enforcement has lots of very sensitive digital information, which is stored and used on the cloud and is in the custody of private companies that are contracted with. The same is true for the banking and medical industries. It is a currently-accepted practice to do that.

Innovative Collaboration

- The bottom line is, by having three of California's four largest counties involved in this consortium, the leveraging of that funding is providing the opportunity for the smaller counties. There are another seven smaller counties in this next batch that would get this technology that would not otherwise be able to do it.
- The innovation in these counties collaboratively coming together to do this is the basis of what the Commission is supposed to be looking to approve.

Commissioner Mitchell agreed but asked if there was something the Commission can see about where the counties are in the process.

Chair Boyd paused the Technology Suite presentation. He asked Ms. Kalk to get together with her team and put together a five-minute demonstration to resolve Commissioner concerns.

[Chair Boyd moved the Commission on to Agenda Item 7, the naming of the fellowship programs, while the Technology Suite Collaborative Innovation Project team worked on Chair Boyd's request. See below for discussion f Agenda Item 7.]

[After the completion of business for Agenda Item 7, the Commission resumed discussion on the Technology Suite Collaborative Innovation Project.]

Ms. Kalk stated appreciation for the opportunity to show the progress to date on the proposed project. She referred to the Technology Suite Implementation Timeline presentation slide and noted the milestones that have been achieved to date. She stated the core venders are in place.

Ms. Kalk stated the first application, Mindstrong, has been deployed in Kern and Modoc Counties. Orange County is in the process of deploying Mindstrong in several of their clinics and Los Angeles County is preparing to deploy Mindstrong in their DVT clinic.

Paul Dagum, M.D., Ph.D., Founder and CEO, Mindstrong Health, showed a demonstration of the Mindstrong app and new innovation that they have done on the collaborative's behalf for Los Angeles County. He showed an aspirational video about the Mindstrong app and a series of slides to give additional information about Mindstrong.

Glen Moriarty, Founder and CEO, 7 Cups, walked Commissioners through the 7 Cups landing pages for the participating counites to demonstrate the customization capability that has been accomplished for Cohort #1.

Ms. Kalk stated they would be happy to return to provide further detail at a future Commission meeting.

Public Comment

Poshi Walker spoke in opposition to the proposed project. The speaker stated ACCESS California and Out for Mental Health have provided written and public comment voicing concerns about the Technology Suite throughout the process. It is not innovative because there are already five counties trying this and there is already a cohort. If this is approved, the Commission will be spending over $100 million on an unproven modality.

Mandy Taylor referred to the sample policies and particularly highlighted number two, ensuring culturally accurate and affirming information, support, and resources. The speaker stated the Technology Suite should be moderated by qualified community members who are compensated for their time and labor. Individuals who know what they are talking about should be the ones providing support.

Mandy Taylor pointed out policy recommendation number ten, that counties or cities prioritize community outreach and in-person engagement using the integrated service model that is required by the Mental Health Services Act. The speaker stated a warm handoff is one of the only value-added components of this project that cannot be found by another application that can be downloaded. The only thing that is being added here is the county connection.

Max Geide spoke in support of the proposed project.

Alexis Stokes-Shaw, MHSA Coordinator, Kern Behavioral Health and Recovery Services, spoke in support of the proposed project.

Adrienne Shilton spoke in support of the proposed project.

Ann Collentine spoke in support of the proposed project.

Carmen Diaz stated she is neither for nor against the proposed project. She stated her concern that children have access to apps. She asked about the protection for children and the parents of these children.

Commissioner Discussion

Commissioner Anthony made a motion in support of the additional 10 county Innovation plans and the request that the overall project be moved for involvement by the Subcommittee on

Innovation and Technology and that counties will allow Subcommittee members to participate at a high level in any Technology Suite processes and report back regularly to the Commission.

Commissioner Danovitch asked for clarification on the motion and whether the motion is to approve and to have the Subcommittee on Innovation oversee this project given the size of it and to develop a regular monitoring process.

Commissioner Anthony agreed with the statement and added that it would be not only monitoring but providing information to the Commission.

Commissioner Brown asked to vote separately on Santa Barbara County.

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

The MHSOAC approves each of the following county Innovation plans and directs Subcommittee on Innovation to provide oversight of the Tech Suite Collaboration Innovation project and provide regular updates to the Commission.

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
Tehama	$118,088	2 Years
Tri-City	$1,674,700	3 Years

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

The following Commissioners voted “Yes”: Commissioners Anthony, Brown, Danovitch, Madrigal-Weiss, and Mitchell, and Chair Boyd.

Commissioner Brown recused himself from the discussion and decision-making with regard to Santa Barbara County’s request and left the room pursuant to Commission policy.

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

The MHSOAC approves Santa Barbara County’s Innovation plan and directs Subcommittee on Innovation to provide oversight of the Tech Suite Collaboration Innovation project and provide regular updates to the Commission as follows:

Amount: $4,912,852

Project Length: Five (5) years

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

The following Commissioners voted “Yes”: Commissioners Anthony, Danovitch, Madrigal-Weiss, and Mitchell, and Chair Boyd.

Commissioner Brown rejoined the Commissioners at the dais.

ACTION

7: Naming of the Fellowship Programs

Presenter:

- Rebecca Herzog, MHSOAC Associate Governmental Program Analyst

Rebecca Herzog, MHSOAC, provided an overview, with a slide presentation, of the background, goals, advisory committee role, and nominations for the honorary naming of the Mental Health Policy Fellowship Programs.

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

Ms. Herzog stated the Commission received two additional letters this week in support of the nominees.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen shared the backgrounds and reasons why it was important to her to name the two fellowships after the nominees.

Chair Boyd thanked Sally Zinman and Rusty Selix for sharing their hearts, minds, and spirits so generously.

Public Comment

Max Geide spoke in support of honoring Sally Zinman and Rusty Selix.

Adrienne Shilton spoke in support of honoring Sally Zinman and Rusty Selix.

Poshi Walker spoke in support of honoring Sally Zinman and Rusty Selix.

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

The MHSOAC names the Mental Health Policy Consumer Fellowship in honor of Sally Zinman and the Mental Health Policy Practitioner Fellowship in honor of Rusty Selix.

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

The following Commissioners voted “Yes”: Commissioners Anthony, Brown, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

GENERAL PUBLIC COMMENT

Jonathan Sherin, M.D., Ph.D., Director, Los Angeles County Department of Mental Health, stated there are visiting leaders in the mental health field from around the world learning from Los Angeles. He invited them to share their experience.

Daniele Piccione stated he is from Trieste, Italy, and is here to study the mental health system in the County of Los Angeles. He stated it has been an intensive four days as he has been gathering as much information as possible to try to combine the Los Angeles mental health

system with the European system. He stated his guidelines are extremely peculiar because they come from an experience which is particular in Europe because the system is based on social community services.

Roberto Mezzina, Director, Mental Services, Trieste, Italy, stated Trieste was the first city in Italy to close the Catholic hospitals in 1980 and transformed them into a network of community-based services. The mental health system in Los Angeles has a lot of good points and good innovative practices but is still difficult to navigate in such a large county. He stated treatment gaps should be better addressed in Los Angeles. He stated the need to create a system that is person-centered and rights-based. Los Angeles and Trieste are working together to achieve that goal.

James Bianco, Judge, Mental Health Court, Los Angeles, stated he was part of the contingent from Los Angeles to visit Trieste last November and participate in a conference with representatives from 36 countries. He stated it is difficult to explain how different the system in Trieste is from the mental health system in the United States and particularly Los Angeles. Individuals in the US system try hard to deliver care to individuals who need it but so much time is spent getting bogged down in different pathways. The US mental health system is so fragmented and so much time is spent grappling with that. Of the many amazing things about the mental health system in Trieste, the one that appeals to him the most as a mental health judge is that it is so simple. If someone needs care, they go to the community mental health center. If they need slightly more structure, they go to the community mental health center. If they need someone to come to their home and help them, it is the community mental health center that goes. It is a one-stop-shop for mental health.

Professor Sashi Sashidharan, a psychiatrist based in Glasgow, Scotland, stated he has been closely involved with mental health services for the past 20 years. He stated he is privileged to be here as part of the visiting team. He shared his impressions of the mental health system in Los Angeles. There are some good people, some good innovative practices, and individuals trying to make a difference, but overarching that is the perception of a very complex system that is mostly opaque or impervious to individuals with severe mental health difficulties to negotiate. As a result of that, there is an experience of fragmentation of the services reported by individuals who use the services. It is a system almost in a vacuum without any serious consideration for the welfare or wellbeing of the people the system is supposed to help.

Professor Sashidharan stated, for outcomes of the services, he had only four words: skid row and Twin Towers. He stated the team visited those facilities and it was an extremely moving experience. He stated it is not that the team is not used to failures in their systems, but they have not seen anything like this anywhere else. The experience really got to the team members not only as professionals and psychiatrists but also as human beings. The degree of suffering that the team witnessed will stay with them for a long time. He stated this must not be allowed to happen – not in the richest city in the world. Something ought to be done about it.

Professor Sashidharan stated there are two options available. One is to scale up services, meaning more of the same, or to accept change and make a qualitative difference to the services currently provided. That is what the team hopes to bring to the table with colleagues at all levels from top to bottom who remain committed to changing things, putting the person with mental health problems at the center of it. He stated that is what the teams hopes will happen here – an exemplary practice, which will have an impact not only in Los Angeles, but right across the country, and right across the world.

Chair Boyd asked to hear and see more of the visiting team's work.

Poshi Walker requested a second General Public Comment period earlier in the day. NorCal MHA has heard that CCJDH, formerly COMIO, has been sole-sourced for the criminal justice stakeholder contract, not just to oversee it but to perform it. NorCal MHA is wondering if that is true and whether the immigrant/refugee stakeholder contract will also be sole-sourced. That rumor has been heard, as well.

Dr. Sherin stated he was sorry he was unable to attend yesterday's strategic planning session.

Chair Boyd asked him to share his comments today.

Dr. Sherin stated one of the things he has tried to understand is the different roles of the different entities: the counties, DHCS, CBHDA, MHSOAC, and advocacy groups across the board including consumers. He stated the MHSOAC has an incredibly important role – to transform mental health in this state. He stated the need for help to serve people. If the Commission is positioned such that the ear of the consumers can connect up with the mental health boards across the state to find out what is going on, it can distill that voice and identify needs locally and across the state. And then, with that, in collaboration with all stakeholders including the DHCS, the counties, and other stakeholders, it can identify outcomes. He recommended identifying the outcomes the Commission wants and agreeing on what those outcomes look like, and then holding everyone to that.

Dr. Sherin stated, in order to go after those goals, there needs to be less focus on funding. To succeed, California needs the DHCS to facilitate the work, not to audit everyone to death. Mental health workers do not want to take care of medical charts, they want to take care of human beings. Half the time in the trenches is taking care of auditors, not people.

Dr. Sherin stated he also wanted county governments and boards of supervisors to understand that the state is giving money to the counties and that the counties have their own process for approving activities. Setting the goals and then allowing the counties the flexibility to use the money to take care of people and not bureaucracy will transform the system.

Dr. Sherin asked the Commission to think about things in that manner – collect the voice through the Commission, identify the outcomes that matter, and then help counties with the state to succeed.

ADJOURN

There being no further business, the meeting was adjourned at 5:17 p.m.

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AGENDA ITEM 2

Action

November 14, 2018 Commission Meeting

City of Berkeley Innovation Plan (Extension)

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of the City of Berkeley's request for additional funding for its Innovative project: Trauma Informed Care, which was originally approved on May 28, 2016 for the amount of $180,000. Of that, $109,309 was already spent in the first year. The City of Berkeley is requesting an additional $266,134, increasing the total Innovation budget to $336,825.

(A) Trauma Informed Care - $266,134 - EXTENSION

The Mental Health Services Act 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.

- In 2016, the City of Berkeley received approval of $180,000 for an Innovation project to provide Trauma Informed Care (TIC) for youth throughout Berkeley Unified School District. This collaborative project was designed to provide TIC training to educators and interested parents and bring TIC practices into the public health, mental health and law enforcement sectors. Unfortunately, implementation delays with the contractor (20/20 Vision), led to the withdrawal of the partnering school district. The City of Berkeley is utilizing the Head Start Centers as a new population upon which to test this practice, and is requesting additional funds in the amount of $266,134 (an increase of 47%) in order to complete the project.

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Presenter for Trauma Informed Care:

- Karen Klatt, M.Ed., MHSA Coordinator

Enclosures (3): (1) Biography for City of Berkeley Presenter; (2) Original Staff Summary (5/28/16): Trauma Informed Care; (3) Staff Analysis: Trauma Informed Care.

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

Additional Materials (1): Link to the City of Berkeley's complete Innovation Plan is available on the MHSOAC website at the following URL:
http://mhsoac.ca.gov/document/2018-10/city-berkeley-innovation-plan-trauma-informed-care-plan-update-november-2018

Proposed Motion: The MHSOAC approves the City of Berkeley's request for additional funding in the amount of $266,134 for its Trauma Informed Care previously approved by the Commission on May 28, 2016 as follows:

Name:	Trauma Informed Care
Additional Amount:	$266,134 for a total Innovation project budget of $336,825
Total Project Length:	Five (5) years.

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Biography for City of Berkeley Presenter

INN Project: Trauma Informed Care (Extension Request)

Karen Klatt, M.Ed.
City of Berkeley, Mental Health Services Act Coordinator

Ms. Klatt has worked for the City of Berkeley since 2007 in the role of the Mental Health Services Act Coordinator. For the past three years she has also served as the Staff Secretary to the Berkeley/Albany Mental Health Commission.

Prior to working for the City of Berkeley, Ms. Klatt previously held positions with NPC Research, Northrup Grumman and Caliber Associates providing consulting services on various Substance Abuse Mental Health Services Administration (SAMHSA) federally-funded projects.

Additional work experience includes: program management and direct service provision in community, schools and public settings; program design, development and implementation; coordination with various agencies and individuals for change initiatives; counseling and group facilitation; research and evaluation; database management; and grant writing.

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY—CITY OF BERKELEY

Name of Innovative (INN) Project: Trauma-Informed Care for Educators

Total Requested for Project: $180,000

Duration of Innovative Project: Three (3) Years

Review History

County Submitted Innovation (INN) Project: May 3, 2016.
Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: May 26, 2016.

Project Introduction:

The City of Berkeley proposes to implement Trauma-Informed Care (TIC) training for educators and interested parents in three Berkeley Unified School District schools (one Transitional Kindergarten and two K-5 schools). This proposal leverages ongoing Bay Area efforts to implement trauma-informed practices in public health, mental health, law enforcement and the schools.

The proposed intervention includes limited utilization of external trainers associated with the East Bay Agency for Children's Trauma Transformed ("T 2") Regional Center to train five school district staff as lead trainers. These lead trainers, working with the existing 2020 Vision for Berkeley's Children & Youth (a community-wide collaborative between the City, Berkeley Unified School District, the University of California at Berkeley, and several other community partners), would establish "Peer Support Learning Circles" to spread the training to additional teachers and staff at the three participating schools, beginning with the Transitional Kindergarten in fall 2016, then shifting to the two K-5 schools in January 2017.

Berkeley projects that "approximately 750 individuals will be impacted by this approach, and around 8 percent of that population (60) will be referred to mental health services and supports" as a result. It is unclear whether this is a prediction of an independent effect on service utilization from the 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? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements that the proposed program or project must align with the core Mental Health Services Act (MHSA principles,

promotes learning, fund exploration of a new and/or locally adapted mental health approach/practice, and target one of the four allowable primary purposes.

The Need

Berkeley cites that its overall communityplanning process has called attention to the need to institute supportive services to address trauma in the youth population. Trauma-Informed Care approaches in schools, also referred to as "trauma-informed schools," "trauma-sensitive schools," and "trauma-informed classrooms," are relatively common. One recent journal article, introducing a special issue on "trauma-informed schools," suggested that TIC approaches have been implemented in schools in at least 17 states, whether in clusters of individual schools, district-wide implementation, or even state-wide implementation (including Massachusetts, Washington, and Wisconsin) (Overstreet and Chafouleas, 2016). TIC-based school programs are currently being implemented in a number of California school districts, including San Francisco Unified School District and Oakland Unified School District.

Berkeley did not cite specific data on behavioral or disciplinary problems in Berkeley Unified School District (BUSD) schools or potential trauma-related academic achievement shortcomings in the schools. However, it did note that the City and BUSD, and others, have worked since 2008 in "the development of plans and models for internal and cross-jurisdictional collaboration to remove barriers to learning and to promote healthy development for all Berkeley children and youth," (City of Berkeley, p. 3) in a collaborative called the 2020 Vision for Berkeley's Children & Youth, a collaborative that utilizes "collective impact" principles.

The Response

Berkeley has not identified in its documentation a specific TIC school-based approach or curriculum that it intends to adapt. Hence it is somewhat difficult to assess the degree to which their proposed approach constitutes a substantial change from existing practices. A number of models are available to choose from, including the Massachusetts Advocates for Children framework, which the University of California at San Francisco has adapted in its UCSF Health Environments and Response to Trauma in Schools (HEARTS) project, which it is implementing in San Francisco and Oakland.

The City notes in its application that its review of the research on school system implementation of TIC models shows that, while the interventions often show promising results, where schools utilized outside trainers "the model was not sustainable once the trainers left the system and the funding ended" (City of Berkeley, p. 3).

It should be noted that, while a number of similar trauma-informed schools approaches are being applied around the country, "the impact of professional development training in educational environments has yet to be fully evaluated" (Overstreet and Chafouleas, 2016). The proposed strategy will make a change to an existing mental health approach that has not yet been demonstrated to be effective, including but not limited to adaptation for a new setting, population or community.

Berkeley's proposed strategy to use a "train the trainer" approach and Peer Support Learning Circles, and to invite participation from interested parents, directly addresses the cited concerns that some other interventions that relied on outside trainers have not proven to be sustainable.

The Community Planning Process

Berkeley states that its draft Innovative Project plan was discussed and refined through three MHSA Advisory Committee meetings and two Community Input meetings over a three-month period. Specific information about participation at these meetings was not included in the City's documentation. The plan was posted for public comment March 1, 2016 through March 31, 2016, culminating in a public hearing of its Mental Health Commission on March 31, 2016, whichunanimously approved the plan as drafted.

Learning Objectives and Evaluation

Berkeley cites the following objectives from this project: (1) to create a change in the way teachers view and handle problematic student behaviors (which often mask trauma); (2) to create an increase in access to mental health services and supports for students in need; and (3) to promote better mental health outcomes by increasing student referrals to appropriate mental health services.

Implicitly, the learning objectives thus are whether the "train the trainer" approach can sustainably induce a change in the attitudes that teachers and staff hold and the strategies that they employ in dealing with problematic student behaviors; and, if those anticipated changes are sustained, whether they lead to appropriate mental health referrals and better outcomes for students with mental health challenges.

Berkeley states that it intends to contract with an external evaluator to be involved throughout the project, but that its specific evaluation strategy and methodology has not yet been set. The project anticipates administering pre- and post tests ofstaff participating in trainings, and to gather qualitative and quantitative outcomes data. The project timeline does not specify the gathering of baseline outcomes data prior to initiation of training.

The Budget

The proposed budget is $180,000 for the entire project, designed to run for two academic years plus a startup phase to hire or identify staff, recruit participating schools and lead trainers, and secure contractors. The budget proposes dedicating $29,000 (16.1 percent) for an external evaluator.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance with other requirements under the MHSA. The project explicitly involves community collaboration and utilizes a general approach widely recognized as addressing concerns about cultural competence. Berkeley could further elaborate on steps it intends to take to insure that the project will be implemented in a culturally competent manner.

Berkeley notes that the project will be overseen by an oversight board that includes family members. The City could futher elaborate on its plan for composing and empowering this oversight board.

Trauma-informed school approaches are widely recognized to be wellness-, recovery-, and resilience-focused. The City further asserts that its proposed project will meet the standards for being client-driven. Finally, Berkeley notes that the proposed project is strongly related to its ongoing 2020 Vision for Berkeley's Children & Youth community project and will strongly integrate the service experience of clients and families across BUSD, Berkeley Mental Health, and other partner entities. The City could further

elaborate on how the "collect ive impact" principles of 2020 Vision may help shape this project.

References

City of Berkeley, Department of Health, Ho using & Community Services, Mental Health Division. April 2016. Exhibit A: Mental Health Servic es Act Draft Innovations Plan, Proposed Trauma Informed Care Project.

Overstreet, Stacy, and Sandra M. Chafoul eas. 2016. "Trauma-Informed Schools: Introduction to the Special Issue." *School Mental Health* 8: 1-6.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – CITY OF BERKELEY

Innovative (INN) Project Name: **Trauma Informed Care**

Extension Funding Requested for Project: **$266,134**

Review History:

MHSOAC Original Approval Date: 05/28/2016

- Original Program Dates: 06/01/2016 through 6/30/2018
  Two (2) Years
- Acknowledgement of time extension: May 31, 2018
- Original Budget: $180,000
- New Program Dates: 11/15/2018 through 6/30/2021
- New Budget: $266,134

Approved by the City Council: October 30, 2018
County Submitted Innovation (INN) Project: June 26, 2018
MHSOAC Consideration of INN Project: November 15, 2018

Project Introduction:

In 2016, the City of Berkeley received approval of $180,000 for an Innovation project to provide Trauma Informed Care (TIC) for youth throughout Berkeley Unified School District. This collaborative project was designed to provide TIC training to educators and interested parents and bring TIC practices into the public health, mental health and law enforcement sectors. Unfortunately, implementation delays with the contractor (20/20 Vision), led to the withdrawal of the partnering school district. The City of Berkeley is utilizing the Head Start Centers as a new population upon which to test this practice, and is requesting additional funds in the amount of $266,134 (an increase of 47%) in order to complete the project.

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

During the first two years of this Innovation plan, decisions around personnel actions and staffing/work load made by Berkeley Unified School District required the City to rethink their effort to implement Trauma Informed Care. As originally approved, it was the intention of the City to utilize the 20/20 Vision Program to conduct trainings in the various schools throughout the district. After the first year, due to staff vacancies in the 20/20 Vision staff, insufficient data was collected.

After new 20/20 Vision staff were hired, participant schools were approached, however, due to additional training requirements for teachers and administrators, this TIC training could not be prioritized within the school district. The City of Berkeley decided to test this model on youth from Head Start Centers. City of Berkeley staff approached Head Start Centers and found that they were interested in implementing the TIC project for their early childhood educators and staff.

According to statistics provided by the YMCA of East Bay, approximately 90% of the 368 families it serves meet the federal poverty guidelines ($25,100 for a family of 4). Furthermore, they indicate that at least 10% of those served have disabilities. It has been found that children traumatized by poverty, racism and other negative social determinants who act out or who are problematic in the classroom, may be further traumatized with traditional disciplinary actions. Finally, the Head Start program normally hires its own graduates or parents of Head Start students and it is critical that those staff understand the nature of their own traumas and the impact those may have on their treatment of students.

Currently the Head Start population in Berkeley is represented by 31% African American, 26% Latino, 5% Asian, 4% White, 4% multi-racial, 4% other and 26% race/cultural unspecified participants, aged from birth to age five.

The Response

In 2016 the City of Berkeley proposed to pilot a project that would change the existing mental health approach of Trauma Informed Care for educators and embed the TIC model in Berkeley schools. They anticipated that the new model would “assist educators in becoming aware of their own trauma/trauma triggers” (p.6, original Innovation Proposal) so that they would be better able to identify and support students who may be suffering from traumas, as evidenced by acting out behaviors. It was anticipated that the project would create consistency and sustainability through a train the trainers approach, increase understanding around trauma related behaviors, provide ongoing support for

teachers with the implementation of peer support activities and test if this method provided belter mental health outcomes for students. The original pilot test was conducted in two K-5 schools and one Transitional Kindergarten and the City anticipated being able to reach 750 students. **City may wish to explain (1) what they learned in the first year, and what if any of that investment could be used and (2) what additional learning can the City expect with this additional funding.**

For this Extension request, the City is not anticipating changing any of the protocols or evaluation methods originally designed for this project. With the additional time required to complete this project, the county is requesting additional funds to cover the costs of serving this new population over the next two years. It anticipates being able to serve 500 participants through the following activities:

- Implement a train the trainer approach to build capacity and sustainability in participating Head Start programs (training includes trauma understanding, cultural humility and responsiveness, safety and stability, compassion and dependability, collaborations and empowerment, residence and recovery)
- Implement the project through a learning collaborative through 20/20 Vision who will provide ongoing support through Peer Learning Circles
- Focus on Head Start educators and staff recognition of their own trauma/trauma triggers as a conduit to better understanding children's behaviors
- Invite parents to participate in the training
- Serve a population that includes very young children and their families. (p. 11)

The Community Program Planning (CPP) Process

The CPP for this extension was conducted over a two-month period (May to June 2018), and included two MHSA Advisory Committee meetings and four (4) Community Input meetings. A public hearing was conducted on July 26, 2018, after a 30-day posting, and comments are included as part of the City's extension request as well as being incorporated in the development of this plan (see Appendix Public Comments). Furthermore, funds for this extension are being taken from the City's AB 114 Plan, which was also vetted through a public comment period and approved by the City Council on July 24, 2018.

Learning Objectives and Evaluation

With this extension, the City of Berkeley intends on shifting the target population from those in the Berkeley Unified School District to four YMCA Head Start Centers within the Berkeley area. It is estimated that with this extension, approximately 500 individuals will be served during the duration of the project.

Although not a very robust evaluation plan, the City of Berkeley has identified a few key components that will assist in testing the evaluation of their project. The main goal of the project is to test whether the Trauma Informed Care (TIC) approach in training can assist underserved children in receiving the necessary services and supports relative to trauma and stress induced behaviors. Additionally, the City of Berkeley has identified three intended outcomes:

1. To create a change in the way Head Start educators and staff view and handle challenging student and parent behaviors (which often mask trauma)
2. To create an increase in access to mental health services and supports for children/families in need; and
3. To promote better mental health outcomes by increasing child/family referrals to appropriate mental health services.

To obtain the data for their evaluation, the City will gather information from pre and post training surveys to measure perception, as well as by tracking the number and type of mental health referrals made to measure access to mental health services. Baseline data will be established as the number and types of referrals reported in the year prior to implementation. While methods to gather data for outcomes two and three are sufficient, it is uncertain how the City of Berkeley will determine if educators and staff handle behaviors differently as a result of the training. **The City has stated that further measures and methodologies will be developed once an evaluator is selected**. The final evaluation report will be completed by the selected evaluator.

At the conclusion of the project, the City of Berkeley will disseminate results at community meetings, as well as make them public by also posting on the MHSA website. Additionally, results will be disseminated through the City of Berkeley's Public Information Office and 2020 Vision communications strategies.

The Budget

Funds, previously deemed reverted are taken from FY 2008-09 and funds subject to reversion from FY 2014-15 will be used to fund this project. The total funding requested for this extension is $266,134 as shown below:

$180,000	(Previously approved)
-$109,309	(Expended)
$ 70,691	(Remaining, from previously approved $180,000)
+$266,134	(Requested new funding)

Salaries for the Project Manager and Head Start in the amount of $137,233 represent 51.5% of the total cost;

Operating Expenses for infrastructure, administrative support, mileage, travel office supplies, and prorated space in the amount of $24,000 represent 9% of the total cost;

Contractor costs for training and evaluation in the amount of $62,909 represent 23.6% of the total cost;

Non-recurring expenditures for curriculum, IT required, in the amount of $8,325 represent 3.1% of the total cost; and indirect costs for $33,667 represent 12.6% of the total cost.

The City may wish to identify the source of the indirect costs since City costs are not well differentiated from contractor costs.

Additional Regulatory Requirements

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

References

https://www.vawnet.org/about

http://www.traumacenter.org/products/pdf_files/Trauma_Smart_JCFS.pdf

https://www.wested.org/service/trauma-informed-practices-in-early-education/

http://www.iimhl.com/files/doc/Make_It_So/2016206.pdf

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-10/city-berkeley-innovation-plan-trauma-informed-care-plan-update-november-2018

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AGENDA ITEM 3

Information

November 14, 2018 Commission Meeting

Programs, Providers, and Services Tool

Summary: The Commission will receive a progress report and demonstration of the Programs, Providers, and Services Transparency Tool. Mental Health Services Oversight and Accountability Commission staff will provide an update and demonstration of our new MHSA Transparency Suite Dashboard.

The MHSA Transparency Suite Dashboard is the new home for all online MHSA data transparency tools. The page provides high-level statistics on each county's service need indicators, MHSA budgets, MHSA programs offered, and program outcomes. The Dashboard also provides links to the Fiscal Reporting Tool and two new tools: the Programs Reporting Tool and the FSP Dashboard.

The Programs Reporting Tool is a searchable inventory of all MHSA programs, built initially around the counties' 2017-20 Three-Year Plans. Users can search for programs using keywords and filters, view high-level program descriptions and characteristics, and compare up to three programs at a time side-by-side.

The Full Service Partnership (FSP) Dashboard begins to share data on outcomes and clients served in MHSA programs. The Dashboard provides statewide and county-level information on budgets, clients served, and client outcomes for FSP programs.

Presenters:

- Rachel Heffley, Associate Governmental Program Analyst
- Brandon McMillen, Associate Governmental Program Analyst

Enclosure (1): Presentation storyboard and Screenshots.

Handouts: None.

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Oversight & Accountability Commission

MHSOAC Transparency Suite

Rachel Heffley
Brandon McMillen

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

The MHSOAC has developed 3 transparency tools, with plans to develop additional utilities. The MHSA Transparency Dashboard was created to have a centralized location to access our entire suite.

The MHSA Transparency Dashboard Follows

Fiscal Transparency

Program Services

Outcomes

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MHSA Transparency Dashboard

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This interactive site is your gateway to explore the MHSOAC Transparency Tool Suite. Discover how counties are spending their MHSA dollars with the Fiscal Transparency Tool. Search and compare MHSA programs with the MHSOAC Programs Reporting Search. Learn more about MHSA's largest funded program type with the Full Service Partnership Visualization. Click on each card below to explore what our tools have to offer.

Riverside

FY 2016-17

Money

2,415,955 People
(4th Highest in CA)

35.60% in Poverty (28th Highest in CA)

Learn How DCHS Determines MHSA Allocation

$153,903,046
Total Expenditures

6.61% of Statewide MHSA Expenditure

Discover Fiscal Transparency with the Fiscal Transparency Tool

Programs

33
MHSA Programs

2.26% of Statewide MHSA Programs

Search and explore programs with the MHSOAC Program Search Tool

Outcomes

Note:
This is Test Data

76.5%

Of FSP clients that met goals
(FY 2012-13 through FY 2016-17)

Learn More about the largest funded MHSA program with the FSP Dashboard

Riverside MHSA Programs FY 2016-17

Note:
Data is from RER

Programs	# Programs	Program Expenditures	Administrative Expenditures
CSS	9	$122,754,417	$18,753,375
PEI	14	$15,962,671	$3,088,328
INN	4	$1,789,270	$410,046
WET	5	$2,672,811	$296,124
CFTN	1	$10,723,877	$0
Other MHSA	0	$0	$0
Total	**33**	**$153,903,046**	**$22,547,873**

County of Riverside Department of Mental Health
Crisis Line: (951) 686-4357 or (951) 509-2499
Warm Line:
Administration:
(951) 413-5678
https://www.rcdmh.org

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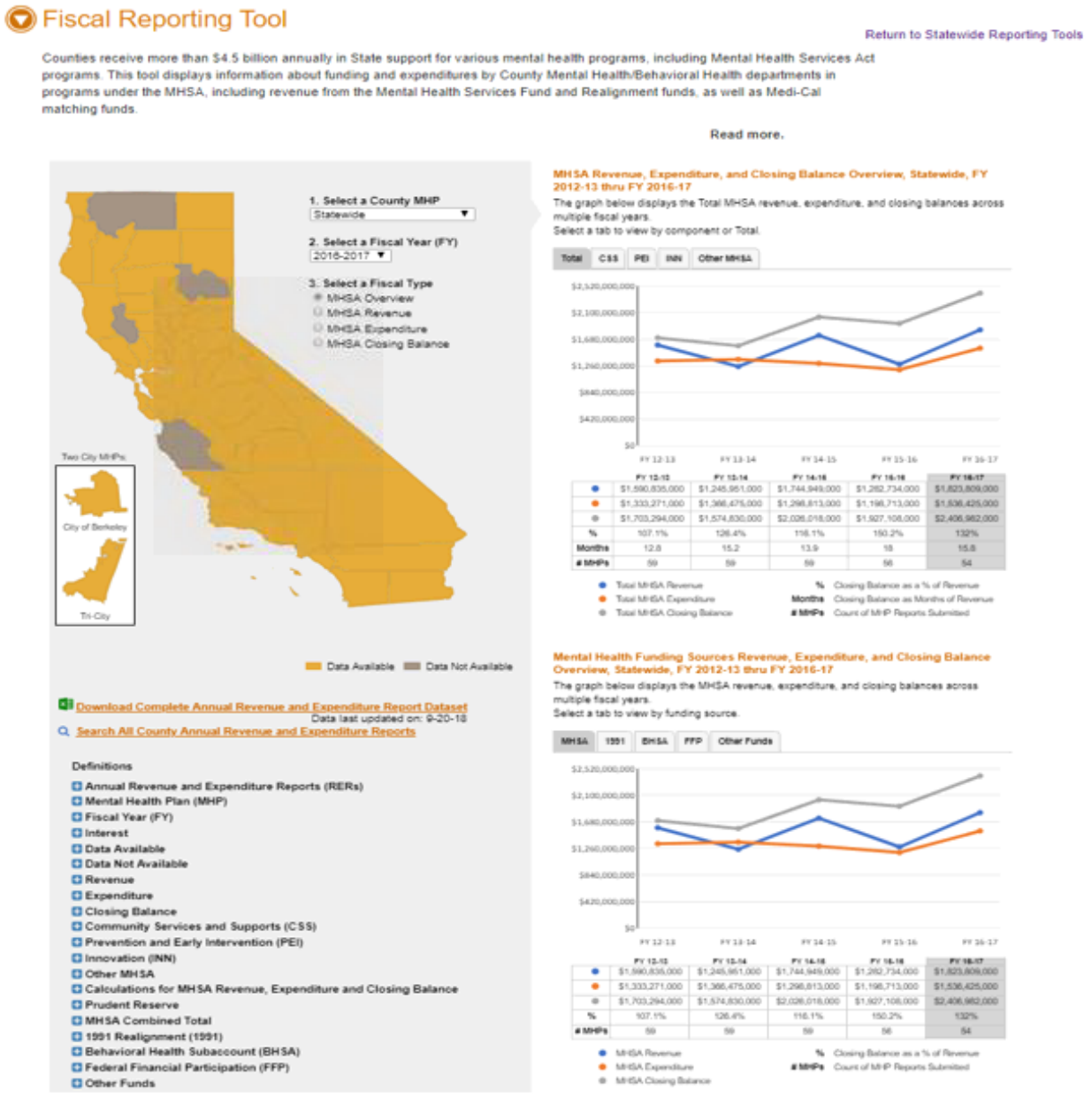
Fiscal Reporting Tool



Financials

The Fiscal Reporting Tool visualizes the complex data surrounding the financial side of the MHSA. The inviting California map makes it possible to view statewide aggregate information or filter by a specific county. There are four pages within the tool that focus on different aspects of county utilization of funds.

1: MHSA Revenue: Revenues the counties receive are visualized on a pie chart displaying the proportion of funding the three main MHSA components CSS, PEI, INN represent.

2: MHSA Expenditure: The same pie chart displays the proportion of expenditures by component. A bar chart shows which allocation year the county expended MHSA Funds. A double 100% stacked bar chart compares the proportional spending on components to the statewide aggregate.

3: MHSA Closing Balance: The pie chart displays the proportion of closing balance at the end of the Fiscal Year each component represents. The bar chart shows which allocation years retain MHSA Funds. The 100% stacked bar charts compares the closing balance for components to the statewide aggregate.

4: MHSA Overview: The MHSA Overview compiles all of the fiscal information available in the three other pages and displays the interaction between them over 5 year periods.

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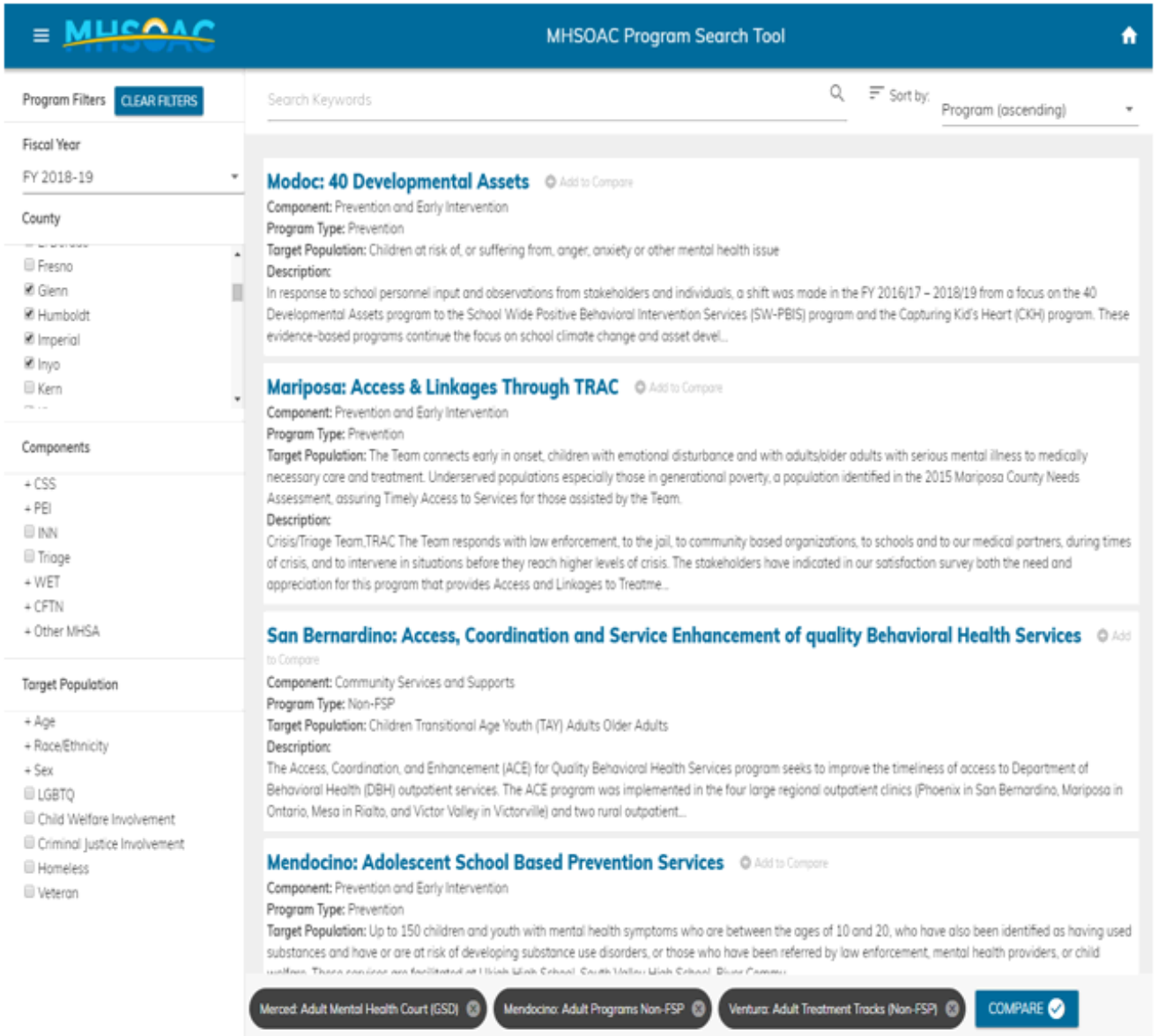
Program Discovery Page



Discover

Using the Program Discovery page users can browse for programs funded through the MHSA, similar to many e-commerce sites. The refinement tools available on the page will make discovering programs fast and easy.

1: Search: A keyword search will allow users to apply specific parameters to their search. Adding multiple keywords will allow the user to hone in on the exact program they are searching for.

2: Filter: There are four filters available to aid in discovering similar programs.

- Fiscal Year: Discover the programs planned in a specific fiscal year
- County: Discover programs in a county, multiple counties, or statewide
- Component: Discover programs offered in one or multiple MHSA components
- Target Population: Discover programs that specifically target defined populations.

3: Sort: Sort programs alphabetically and by county to speed discovery.

4: Results: Results of a search are displayed so the user can identify what program(s) they would like to explore further in the Program Profile.

5: Comparison Queue: Users can add up to 3 programs to a queue for comparison

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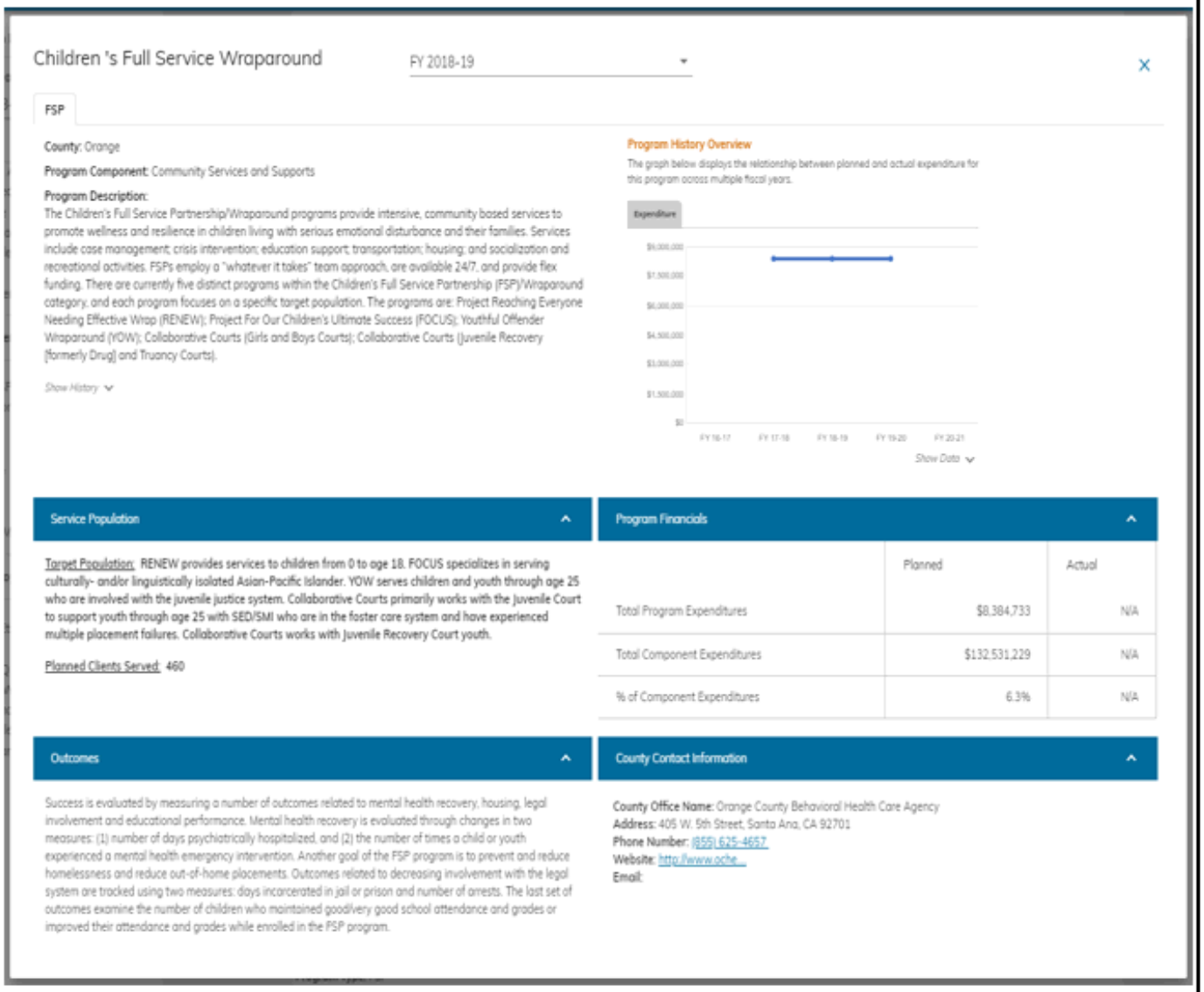
Program Profile



Learn

The Program Profile provides a wealth of planning information for a program in an easy to follow and concise display.

The information on the program profile extracts data provided by counties in the MHSA Three Year Program and Expenditure Plans, and Annual Updates.

The MHSOAC has identified from regulations and stakeholder feedback the consistent information vital to know about MHSA Programs. The information available are:

- County,
- Program Name,
- Component,
- Program Type
- Program Description
- Target Population Narrative,
- Planning and Actual Financials,
- Planned Outcomes,
- County Contact Information,
- Over Time Planned/Actual Expenditures.

In the future, additional information will be provided on the profile pertaining to data extracted from retrospective reports submitted by counties. Users will be able to compare what a county planned to do and the outcomes that resulted.

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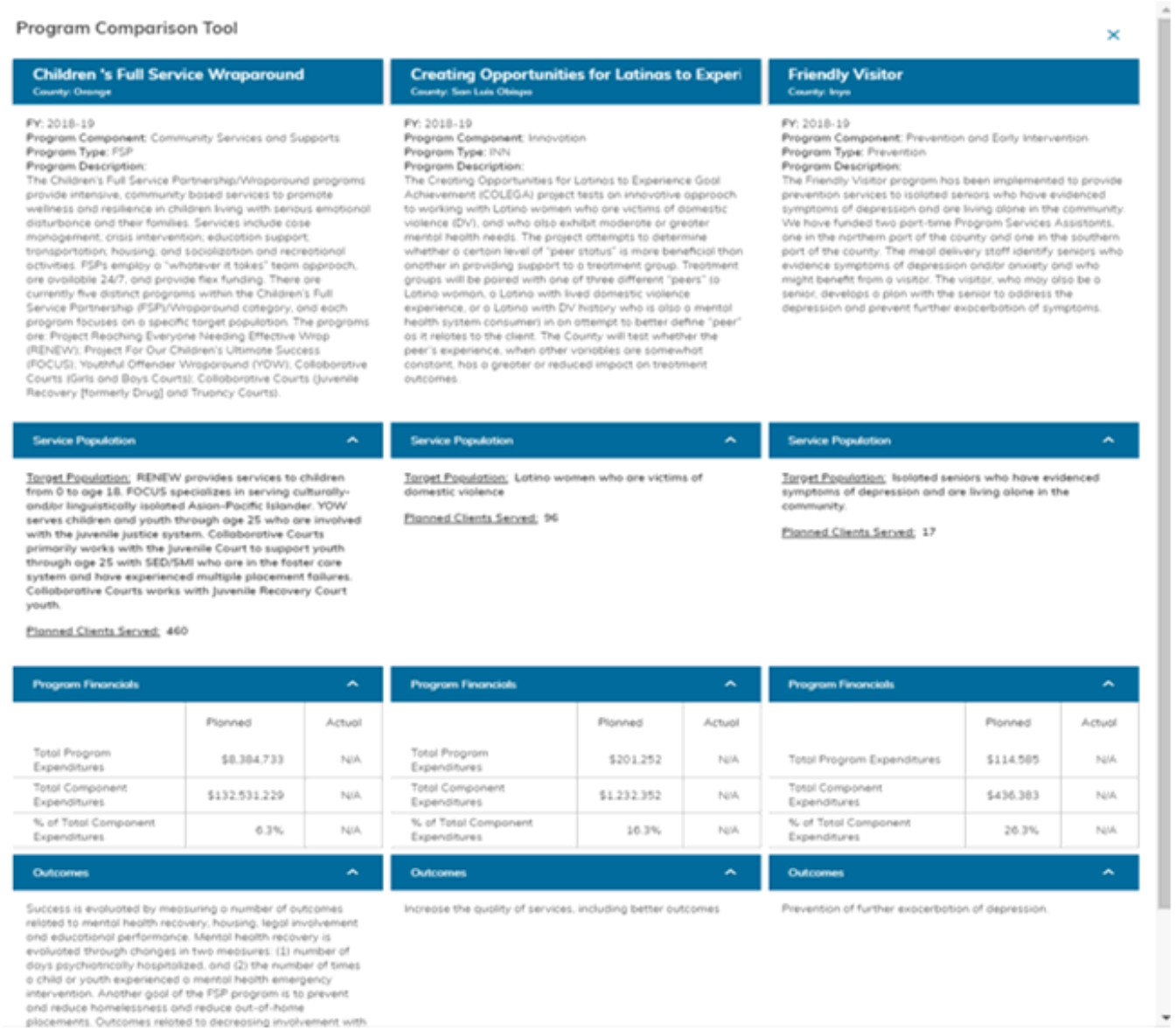
Program Comparison



Program Comparison Tool

Children 's Full Service Wraparound County: Orange	Creating Opportunities for Latinas to Experi County: San Luis Obispo	Friendly Visitor County: Inyo
FY: 2018-19 **Program Component**: Community Services and Supports **Program Type**: FSP **Program Description**: The Children's Full Service Partnership/Wraparound programs provide intensive, community based services to promote wellness and resilience in children living with serious emotional disturbance and their families. Services include case management; crisis intervention; education support; transportation; housing; and socialization and recreational activities. FSPs employ a "whatever it takes" team approach, are available 24/7, and provide flex funding. There are currently five distinct programs within the Children's Full Service Partnership (FSP)/Wraparound category, and each program focuses on a specific target population. The programs are: Project Reaching Everyone Needing Effective Wrap (RENEW); Project For Our Children's Ultimate Success (FOCUS); Youthful Offender Wraparound (YOW); Collaborative Courts (Girls and Boys Courts); Collaborative Courts (Juvenile Recovery [formerly Drug] and Truancy Courts).	FY: 2018-19 **Program Component**: Innovation **Program Type**: INN **Program Description**: The Creating Opportunities for Latinos to Experience Goal Achievement (COLEGA) project tests an innovative approach to working with Latino women who are victims of domestic violence (DV), and who also exhibit moderate or greater mental health needs. The project attempts to determine whether a certain level of "peer status" is more beneficial than another in providing support to a treatment group. Treatment groups will be paired with one of three different "peers" (a Latino woman, a Latino with lived domestic violence experience, or a Latino with DV history who is also a mental health system consumer) in an attempt to better define "peer" as it relates to the client. The County will test whether the peer's experience, when other variables are somewhat constant, has a greater or reduced impact on treatment outcomes.	FY: 2018-19 **Program Component**: Prevention and Early Intervention **Program Type**: Prevention **Program Description**: The Friendly Visitor program has been implemented to provide prevention services to isolated seniors who have evidenced symptoms of depression and are living alone in the community. We have funded two part-time Program Services Assistants, one in the northern part of the county and one in the southern part of the county. The meal delivery staff identify seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms.
Service Population	**Service Population**	**Service Population**
Target Population: RENEW provides services to children from 0 to age 18. FOCUS specializes in serving culturally- and/or linguistically isolated Asian-Pacific Islander. YOW serves children and youth through age 25 who are involved with the juvenile justice system. Collaborative Courts primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are in the foster care system and have experienced multiple placement failures. Collaborative Courts works with Juvenile Recovery Court youth. Planned Clients Served: 460	Target Population: Latino women who are victims of domestic violence Planned Clients Served: 96	Target Population: Isolated seniors who have evidenced symptoms of depression and are living alone in the community. Planned Clients Served: 17
Program Financials	**Program Financials**	**Program Financials**

	Planned	Actual
Total Program Expenditures	$8,384,733	N/A
Total Component Expenditures	$132,531,229	N/A
% of Total Component Expenditures	6.3%	N/A

	Planned	Actual
Total Program Expenditures	$201,252	N/A
Total Component Expenditures	$1,232,352	N/A
% of Total Component Expenditures	16.3%	N/A

	Planned	Actual
Total Program Expenditures	$114,585	N/A
Total Component Expenditures	$436,383	N/A
% of Total Component Expenditures	26.3%	N/A

Outcomes	Outcomes	Outcomes
Success is evaluated by measuring a number of outcomes related to mental health recovery, housing, legal involvement and educational performance. Mental health recovery is evaluated through changes in two measures: (1) number of days psychiatrically hospitalized, and (2) the number of times a child or youth experienced a mental health emergency intervention. Another goal of the FSP program is to prevent and reduce homelessness and reduce out-of-home placements. Outcomes related to decreasing involvement with	Increase the quality of services, including better outcomes	Prevention of further exacerbation of depression.

Compare

The Program Comparison page allows users to comparing up to three MHSA programs.

Programs are loaded into the comparison queue from the Program Discovery page by clicking “add to compare” next to a program name and then clicking “Compare” in the comparison queue.

The Program Comparison page pops up to show the 2 or 3 programs the user selected side by side. Each section designated to a program is a simplified version of the program profile. The information available are:

- Fiscal Year
- County,
- Program Name,
- Component,
- Program Type
- Program Description
- Target Population Narrative,
- Planning and Actual Financials,
- Planned Outcomes,

Users can easily compare and contrast the information to learn about the similarities and differences of programs.

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Outcomes: Full Service Partnership Dashboard

WHY FSP?

- ✓ CSS is the largest component making up 80% of CSS Funds
- ✓ FSP accounts for more than 50% of CSS funds therefore FSP accounts for the largest spending
- ✓ Aside from data reported in the 3 year plans, annual updates, and Revenue Expenditure Report MHSOAC has access to robust reported data for FSP clients

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Fiscal Transparency

- What is the percent of CSS expenditures actually spent on FSP programs

Client Services*

- How well are clients being tracked
- What age demographic is being served

*For FSP we get client level data and currently there is no easy way to tie the people to their programs. We are working on a pilot project with three counties and one goal of this project is to be able to tie the people to their programs.

Outcomes

- What percent of discharged FSP clients have met their goals

Mental Health Services
Oversight & Accountability Commission

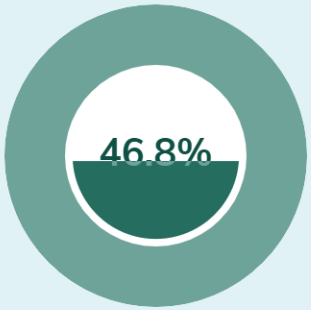
Full Service Partnerships (FSP)

The Full Service Partnership (FSP) is a category of allowable costs within the Community Services and Support component of the Three-Year Program and Expenditure Plan. The California Code of Regulations, Title 9, Section 3200.130 defines an FSP as "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals." FSPs are the largest funded MHSA program type. Below you will find hi-level statistical data of each counties' FSP programs. All data has been scrubbed to remove any Protected Health Data (PHI).

FY 2016-17 | FSP Data for | Statewide

Hi: 94.3%
Low: 6.3%

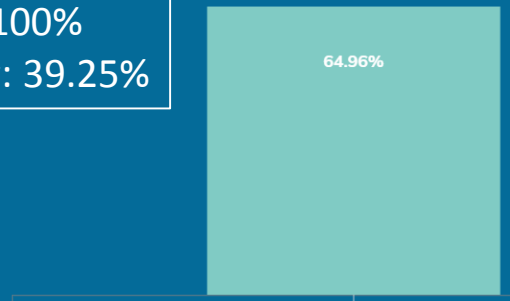
FY 2016-17 FSP Percent
Of CSS Expenditures



% of expenditures is calculated by FSP Expenditure (Excluding Admin Costs)/CSS Expenditure (Including Admin Costs)

FY 2016-17 Percent of Clients Tracked and Assessed

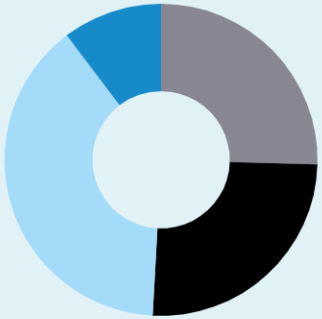
Hi: 100%
Low: 39.25%



This figure is determined by the percentage of FSP clients who were not disenrolled that had either a KET or 3M during that Fiscal Year

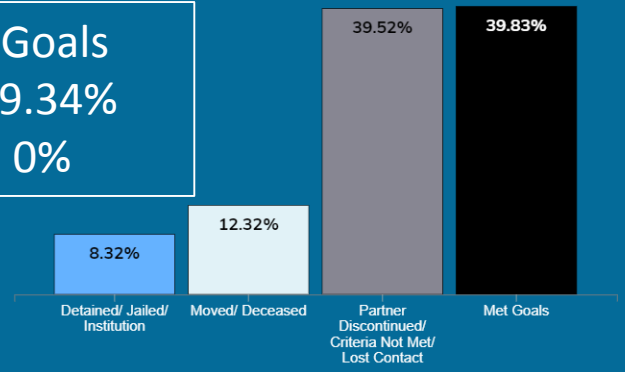
Test Data

Percent of Clients Served by Age
FY 2012-13 through 2016-17



Disenrollment Reasons (FY 2012-13 through 2016-17)

Met Goals
Hi: 59.34%
Low: 0%



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AGENDA ITEM 4

Information

November 14, 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. The Commission will discuss the Executive Director's report out.

Presenter: Toby Ewing, Executive Director

Enclosures:
(1) The Motions Summary from the October 25, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard (4) Presentation Guidelines; (5) Calendar of Commission Meeting Draft Agenda Items; (6) Department of Health Care Services Revenue and Expenditure Reports status update.

Handouts: None.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
October 25, 2018

Motion #: 1

Date: October 25, 2018 **Time:** 9:08 AM

Motion:

The Commission approves the September 26-27, 2018 Meeting Minutes.

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Mitchell

Motion carried 10 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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☒	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 2

Date: October 25, 2018 **Time:** 1:24 PM

Motion:

The MHSOAC elects Commissioner Aslami-Tamplen as Chair for 2019.

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Bunch

Motion carried 10 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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☒	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 3

Date: October 25, 2018 **Time:** 1:26 PM

Motion:

The MHSOAC elects Commissioner Ashbeck as Vice-Chair for 2019.

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

Motion carried 10 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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☒	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 4

Date: October 25, 2018 **Time:** 3:48 PM

Motion:

The MHSOAC approves Alameda County's Innovation Projects, as follows:

Name: Introducing Neuroplasticity to Mental Health Services for Children

Amount: $2,054,534

Project Length: Four (4) Years

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Mitchell
Vice-Chair Aslami-Tamplen recused herself.

Motion carried 4 yes, 3 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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☐	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 5

Date: October 25, 2018 **Time:** 3:51 PM

Motion:

The MHSOAC approves Alameda County's Innovation Projects, as follows:

Name: Community Assessment and Transportation Team (CATT)

Amount: $9,878,082

Project Length: Five (5) Years

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Bunch
Vice-Chair Aslami-Tamplen recused herself.

Motion carried 6 yes, 1 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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☐	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 6

Date: October 25, 2018 **Time:** 3:52 PM

Motion:

The MHSOAC approves Alameda County's Innovation Projects, as follows:

Name: Emotional Emancipation Circles for Young Adults

Amount: **$**501,808

Project Length: Two (2) Years, Six (6) Months

Commissioner making motion: Commissioner Madrigal-Weiss
Commissioner seconding motion: Commissioner Mitchell
Vice-Chair Aslami-Tamplen recused herself.

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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☐	☐	☐
14. Chair Boyd	☐	☐	☐

Motion #: 7

Date: October 25, 2018 **Time:** 4:32 PM

Motion:

The MHSOAC approves San Francisco County's Innovation plans, as follows:

Name: Wellness in the Streets

Amount: **$**1,750,000

Project Length: Five (5) Years

Commissioner making motion: Commissioner Ashbeck
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 Wooton	☐	☐	☐
13. Vice-Chair Aslami-Tamplen	☒	☐	☐
14. Chair Boyd	☐	☐	☐

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MHSOAC Evaluation Dashboard October 2018
(Updated October 25th, 2018)

Summary of Updates

Contracts

No Changes

Total Contracts: 4

Funds Spent since September 2018 Dashboard

16MHSOAC021	$75,000
17MHSOAC024	$0
17MHSOAC081	$100,000
17MHSOAC085	$0
Total	$175,000

Contracts with Deliverable Changes

17MHSOAC081

MHSOAC Evaluation Dashboard October 2018
(Updated October 25th, 2018)

The iFish Group: Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff	Brandon McMillen & Rachel Heffley
Active Dates	10/31/16 – 7/27/2019
Total Contract Amount	$1,000,000
Total Spent	$850,000

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 Date	Status	Change
Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	10/31/16	Complete	No
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)	05/30/18	In Progress	No
Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	07/28/18	Complete	No

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MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

MHSOAC
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	$286,843

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.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	12/28/17	No
Visualization Portal	Complete	12/28/17	No
Data Management Support Services	In Progress	12/31/18	No

MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

Mental Health Services
Oversight & Accountability Commission

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff	Michelle Adams
Active Dates	7/1/20185-7/31/2020
Total Contract Amount	$1,200,000
Total Spent	$100,000

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.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/19	Yes
Outcomes Reporting Draft Report	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

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

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

Deliverable	Status	Due Date	Change
FSP Program Data Sets	Not Started	1/25/19	No
FSP Formatted Data Sets	Not Started	5/06/19	No
FSP Draft Report	Not Started	6/28/19	No
FSP Final Report	Not Started	8/30/19	No

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INNOVATION DASHBOARD - NOVEMBER 2018
(Current)

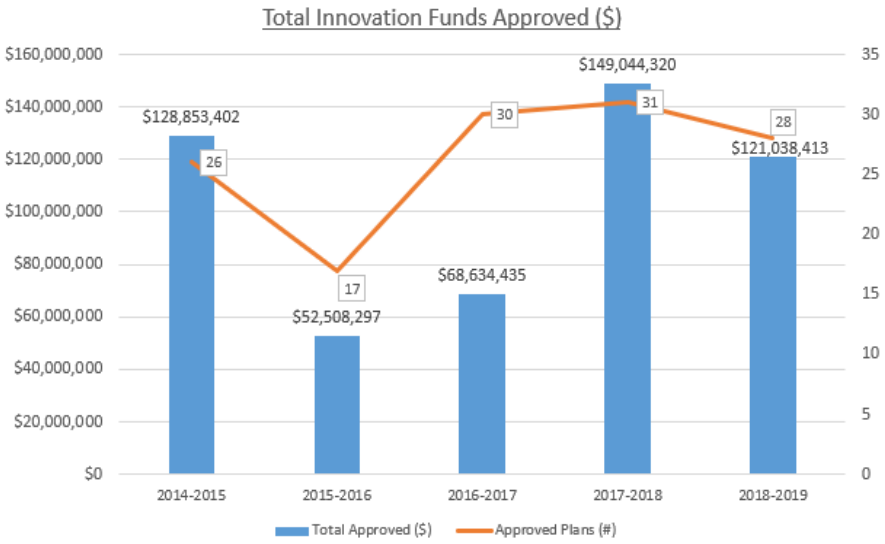
	NUMBER OF PLANS	COUNTIES	FUNDS REQUESTED
CALENDARED*	8	8	$14,022,057
DRAFT PROPOSALS RECEIVED	4	4	$20,634,267
TOTAL	**12**	**12**	**$34,656,324**

AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
50 days†

Draft → Final → Calendared

* **November:** City of Berkeley (1), Early Psychosis Project: San Diego (1), Solano (1), Orange (1), and Los Angeles (1)
January: Calaveras (1), San Francisco (1), San Benito (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 ǂ	
54	**92%**

ǂ 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	$117,907,293
APPROVED Ext. Funds:	$1,111,054	$5,587,378	$2,008,608	$5,172,606	$3,131,120
Plans Received:	N/A	N/A	33	34	28
Plans APPROVED:	26	17	30 (91%)	31 (91%)	28 (100%)
Participating Counties:	16	15	18 (31%)	19 (32%)	20 (34%)
Participating Counties APPROVED:	N/A	N/A	17 (94%)	16 (84%)	20 (100%)

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STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	City of Berkeley	Trauma-Informed Care for Educators	$336,825.00	3 Years	6/29/2018	9/4/2018	NOVEMBER
CALENDARED	San Diego	Statewide Early Psychosis Learning Health Care Network	$1,127,389.00	5 Years	9/10/2018	10/12/2018	NOVEMBER
CALENDARED	Solano	Statewide Early Psychosis Learning Health Care Network	$414,211.00	5 Years	9/10/2018	10/12/2018	NOVEMBER
CALENDARED	Los Angeles	Statewide Early Psychosis Learning Health Care Network	$4,545,027.00	5 Years	9/10/2018	10/12/2018	NOVEMBER
CALENDARED	Orange	Statewide Early Psychosis Learning Health Care Network	$2,499,120.00	5 Years	9/10/2018	10/12/2018	NOVEMBER
CALENDARED	Calaveras	Enhancing the Journey to Wellness Peer Specialist Program	$710,609.00	5 Years	6/6/2018	9/17/2018	JANUARY
CALENDARED	San Francisco	FUERTE	$2,124,310.00	5 Years	10/9/2018	10/16/2018	JANUARY
CALENDARED	San Benito	Behavioral Health-Diversion and Re-Entry Court	$2,264,566.00	5 Years	8/28/2018	10/18/2018	JANUARY

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	Colusa	Social Determinants of Rural Mental Health Project	$403,419	3 Years	8/30/2018		
DRAFT	San Bernardino	Innovative Remote Onsite Assistance Delivery-InnROADS	$17,024,309	5 Years	9/12/2018		
DRAFT	Mono	Eastern Sierra Learning Collaborative: A County Driven Regional Partnership	$84,935	2 Years 9 Months	10/1/2018		

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Imperial	Positive Engagement Team (PET)	$3,121,604	5 Years	10/9/2018		

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

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. **County Brief**
    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

3. **PowerPoint Presentation**
    a. 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?

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.

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Calendar of Commission Meeting Draft Agenda Items

Proposed 11/02/18

All agenda items and meeting locations are subject to change

December: No Meeting

January 24: Sacramento, MHSOAC

- **Innovation Project: Calaveras County**
  Enhancing the Journey to Wellness Peer specialist Program
- **Innovation Project: San Francisco**
  Fuerte
- **Innovation Project: San Benito**
  Behavioral Health Diversion and Re-entry Court
- **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.
- **Use of County Innovation Funds**
  The Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.
- **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.
- **Immigrant/Refugee RFP Outline**
  The Commission will consider approval of an outline for an Immigrant and Refugee RFP.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

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.

April 25: Anaheim

- **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.

Agenda Item 4, Enclosure 6: DHCS Status Chart of County RERs Received
November 14, 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 October 26th, 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

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	9/12/2018	9/12/2018	
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	10/4/2018	10/4/2018	10/4/2018		10/4/2018
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	10/8/2018		10/15/2018
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	9/25/2018		9/27/2018
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	59	59	59		57

Current Through: 10/26/2018

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AGENDA ITEM 5

Action

November 14, 2018 Commission Meeting

Early Psychosis Learning Health Care Network Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will hear a combined presentation from the Early Psychosis Learning Health Care Network (LHCN), a collaborative of four counties. The Commission will consider approval of the following counties and their innovation funding request:

COUNTY	Total INN Funding Requested
Los Angeles	$4,545,027
Orange	$2,499,120
San Diego	$1,127,389
Solano	$414,211
Total	**$8,585,747**

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, Orange, San Diego, and Solano Counties are seeking approval from the Commission to use innovation funds to develop the infrastructure for a sustainable Learning Health Care Network for Early Psychosis (EP) programs, including training and technical assistance to EP program providers over five years in order to increase the quality of services including measurable outcomes.

The Counties are collaborating with the UC Davis Behavioral Health Center of Excellence and supported by partnerships with UC San Francisco, UC San Diego, University of Calgary, and One Mind.

The project intends to bring consumer-level data to clinicians in real-time, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the United States.

- The value of the project will be examined through a statewide evaluation that will assess the impact of the Learning Health Care Network on consumer- and program-level metrics, as well as utilization and cost rates of EP programs.

Presenters:

- **Tara Niendam, Ph.D.,** Associate Professor in Psychiatry, UC Davis. Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics).
- **Mark Savill, Ph.D.,** Assistant Professional Researcher, UCSF
- **Debbie Innes-Gomberg, Ph.D.,** Deputy Director, Los Angeles County Department of Mental Health
- **Tracy Lacey, LMFT,** Senior Mental Health Services Manager, MHSA Programs. Solano County Department of Health and Social Services.

Enclosures (3): (1) Biographies for Early Psychosis Learning Health Care Network, Presenters, (2) Staff Analysis for Early Psychosis Learning Health Care Network, (3) Brief for Early Psychosis Learning Health Care Network

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

Additional Materials (1): Link to the Early Psychosis Learning Health Care Network Innovation Proposal is available on the MHSOAC website at the following URL:

http://mhsoac.ca.gov/document/2018-10/early-psychosis-learning-health-care-network-statewide-collaborative-november-2018

Proposed Motions (4): The MHSOAC approves each of the following County's Innovation plans, as follows:

COUNTY	Total INN Funding Requested	Duration of INN Project
Los Angeles	$4,545,027	5 Years
Orange	$2,499,120	5 Years
San Diego	$1,127,389	5 Years
Solano	$414,211	5 Years

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Biographies
Multi-County Early Psychosis Learning Health Care Network

Tara Niendam, Ph.D. Associate Professor in Psychiatry, UC Davis. Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics)
Dr. Niendam is interested in improving outcomes and supporting recovery for youth in the early stages of psychosis. She leads a variety of research projects that focus on reducing the duration of untreated psychosis through technology-assisted interventions, examining the use of smartphones as part of clinical care for youth with psychosis, and evaluating program-related outcomes for early psychosis clinics across California.

Mark Savill, Ph.D. Assistant Professional Researcher, UCSF
Dr. Savill is an Assistant Researcher in the University of California, San Francisco Department of Psychiatry. Dr. Savill investigates methods for early identification of psychosis and implementation of early intervention to treat psychosis, utilizing both qualitative and quantitative methodologies.

Debbie Innes-Gomberg, Ph.D. Deputy Director, Los Angeles County Department of Mental Health
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.

Tracy Lacey, LMFT Senior Mental Health Services Manager, MHSA Programs. Solano County Department of Health and Social Services
Tracy Lacey, LMFT, is a Senior Mental Health Services Manager in the role of the Solano County Behavioral Health MHSA Coordinator since 2015. Prior to her current position, Tracy held supervisory positions in the Quality Improvement Unit and the Adult Forensic Full Service Partnership Unit for Solano County Behavioral Health. Before joining the County in 2014, Tracy worked for a non-profit organization for over a decade in various positions culminating in a Clinical Program Director position overseeing a mental health clinic serving children and families in Solano County.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— MULTI-COUNTY COLLABORATIVE

Innovation (INN) Project Name:
Early Psychosis Learning Health Care Network

Review History

COUNTY	Total INN Funding Requested	Duration of INN Project	County Submitted INN Project	30 day Public Comment	Approved by BOS
Los Angeles	$4,545,027	5 Years	10/12/18	08/14-09/12/18	06/06/18
Orange	$2,499,120	5 Years	10/12/18	06/20-07/20/18	01/2019
San Diego	$1,127,389	5 Years	10/12/18	09/11-10/11/18	11/13/18
Solano	$414,211	5 Years	10/12/18	06/28-07/27/18	09/11/18
Total	**$ 8,585,747**				

Collaborative Project Description

Introduction

Los Angeles, Orange, San Diego, and Solano Counties are seeking approval to use innovation funds to develop the infrastructure for a sustainable Learning Health Care Network (LHCN) for existing Early Psychosis (EP) programs in order to increase the quality of services and improve outcomes. The LHCN will utilize an application to gather real-time data from clients and their family members in existing EP clinic settings, and will also include training and technical assistance to EP program providers.

The Counties propose to contract with UC Davis Behavioral Health Center of Excellence (the Contractor) to lead the project with support from One Mind and partnerships with UC San Francisco, UC San Diego, and the University of Calgary.

The value of the project will be examined through a statewide evaluation that will assess the impact of the Learning Health Care Network on consumer- and program-level metrics, as well as utilization and cost rates of EP programs.

Identified Need

Psychosis is a term used to describe conditions that affect the mind where a person's thoughts and perceptions are disturbed and there is a loss of contact with reality (National

Institute of Mental Health, 2016). Key features that define the psychotic disorders are: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior, and negative symptoms (American Psychiatric Association, 2013).The National Institute of Mental Health presents the following facts about psychosis: about 100,000 adolescents and young adults in the US experience first episode psychosis each year; psychosis often begins when a person is in his or her late teens to mid-twenties; and psychosis affects people from all walks of life (2016). Unfortunately, those who do experience symptoms of psychosis often go untreated for more than a year (Addington, et al 2015).

The participating counties expressed that they would like to further improve outcomes for participants in EP programs while also reducing program costs. While 24 of the 59 counties in California have an EP program **there is lack of standardization and a lack of infrastructure to properly evaluate the fidelity to evidence based practice and the effectiveness of these programs, making it impossible to disseminate best practices across programs.** These demands for effective early psychosis intervention programs combined with legislation requiring EP programs, funding to operate EP programs, and the need to implement quality improvement initiatives, has led the Collaborative to develop this proposal to create the infrastructure for a sustainable Learning Health Care Network (LHCN) for EP.

Discussion

All counties and programs participating in this collaborative operate variations of the CSC model (a world- wide, evidence–based treatment and has been the subject of at least two recent research projects in the United States (Azrin, Goldstein, Heinssen, 2016)). **The LHCN seeks to create infrastructure in California to gather real-time data from clients and their family members in existing EP clinic settings that use CSC. Data will be collected through a developed application via questionnaire on tablets. The collection of data via application and subsequent aggregation will allow programs to learn from each other, and provide the infrastructure to position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US.**

The Collaborative proposal identified three primary areas of focus:

1. Provide infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and “lessons learned” can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
2. Training and technical assistance to support EP program providers to have immediate access to relevant client-level data and anonymized data that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.
3. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

As a result of the project, Counties will be able to learn from each other and from leading experts in early psychosis treatment by using a common framework to improve process and report on outcomes. Currently, counties have no easy way to share data from early psychosis programs and this LHCN is one solution providing a starting point to address the lack of shared data systems.

The infrastructure created by this project will also allow California to participate in the development of a national Early Psychosis Intervention Network (EPINET) (led by the National Institute of Mental Health). Involvement in this national network requires the participating states to have established infrastructure for large scale data collection and reporting. Each of the four counties participating in this collaborative have agreed to participate in the national network and will implement a separate process for informed consent for participating clients.

In addition, development of this LHCN project is in line with Assembly Bill 1315 which includes a goal of "expand(ing) the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in this state" in addition to a goal of "creating public/private partnerships dedicated to expansion of evidence-based prevention and early intervention services would generate additional revenue that would enhance the ability for counties throughout California to create and fund those programs" (Assembly Bill 1315, 2017).

This proposal was informed by a previous contract between UC Davis Behavioral Health Center of Excellence and the MHSOAC where UC Davis proposed to conduct a statewide evaluation of Mental Health Service Act funded or other publicly funded EP programs in California. One outcome of the contract identified by UC Davis is a lack of standardization and lack of infrastructure to properly evaluate the fidelity and effectiveness of existing programs.

Additionally, the MHSOAC has supported the development of this proposal via a small contract with UC Davis to identify potential county partners.

Review of the extant literature indicates that the overview provided by the Collaborative to justify the need for this program is supported by current research, legislation and local need. Commission staff were unable to identify any other existing early psychosis related project that includes training and technical assistance to help providers utilize data in real time to improve consumer outcomes, nor is there an existing evaluation examining the impact of the LHCN on the Early Psychosis programs.

Learning and Evaluation

This project attempts to modify and implement a software application to accomplish, among other things, uniformity in how and what is collected by individual EP programs, using best practices and standardized tools. Within this network are four initial counties that will be participating. While some variation is expected at the county-level, the overall evaluation will utilize aggregate data collected from multiple sources across counties. **The Collaborative may wish to address how variance in county data will affect the evaluation and how it will be controlled.**

Though the overall evaluation of the collaborative project will involve a number of different individuals and entities, the project will mainly target individuals at increased risk or in the early stages of a psychotic disorder. It is important to note, however, that there may be variation in the intake criteria at the county program level (i.e. excluding individuals with comorbid diagnoses or individuals unable to commit to program duration). Over the course of the project, it is estimated that between 2,000-2,500 individuals will be served by existing programs.

This section summarizes the ways in which the Collaborative will evaluate the impact of the LHCN on the EP care network, as well as the effect of EP programs on consumer- and program-level outcomes. Under the guidance of the University of California, Davis, in partnership with UC San Francisco, UC San Diego, the University of Calgary, and One Mind, the evaluation for the LHCN collaborative project will take on three different approaches. These three approaches coalesce into a robust evaluation that meet the goals of the project, and include: the utility of the LHCN for early psychosis programs, fidelity of early psychosis programs within counties, as well as the impact that early psychosis programs have on costs and individual outcomes—each approach is summarized below.

(1) *Utility of the LHCN for early psychosis programs*: This will be accomplished by utilizing information gathered from two samples of consumers and providers prior to LHCN implementation. The first sample of consumers will complete questionnaires at year 1 (pre-implementation period). Questionnaires will gather information on knowledge of illness, Perceived Effect of Use for the LHCN, Treatment Satisfaction, Treatment Alliance, and Comfort with Technology. Providers will also complete a questionnaire on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. The second sample of consumers and providers will complete these same questionnaires post-implementation at year 4.

(2) *Fidelity of early psychosis programs*: Using the revised First Episode Psychosis Services Fidelity Scale (FEPS-FS), the Collaborative will assess each clinic's adherence to evidence-based practices for first-episode psychosis services. Scores from the FEPS-FS will provide insights into components of each EP program that are associated with outcomes.

(3) *Impact of early psychosis programs on costs and outcomes*: Using three different data sources—program-level data, qualitative data, and county-level data—the impact that EP programming has on individual consumer outcomes as well as related costs will be examined (**see pgs.12-16 of Collaborative plan**).

   a. Program-Level Data: upon consideration from stakeholder engagement discussions (**see qualitative data**), specific data elements will be selected and will stand as the foundation for the LHCN. Providers, consumers, and family members will identify measures of potential outcomes from the PhenX Early Psychosis Toolkit, the national Mental Health Block Grant, and others (**for specific measures and outcomes, see pgs. 13-15 of Collaborative plan**).

b. Qualitative Data: focus group interviews, and in-depth semi-structured interviews will be conducted with consumers, family members, and providers. With this method, feedback will be garnered at different stages of the project. This includes feedback relative to identifying appropriate measures for use in the project. Additionally, these methods will allow evaluators to assess the feasibility of the implementation strategy, and provide context to the interpretation of data analysis.
c. County-Level Data: consumer-level data relative to program service utilization, crisis/ED utilization, psychiatric hospitalization, and costs related to these utilization domains will be captured at the county-level.

These three evaluation approaches will be guided by several learning questions, including:

1. Do consumer and/or provider skills, beliefs and attitudes about technology or measurement-based care impact completion of LHCN outcome measures or use of data in care?
2. Does engagement in the LHCN impact consumer satisfaction with care, insight into treatment needs, and alliance with treatment team?
3. Are there differences in utilization and costs between EP programs and standard care?
4. How does utilization and cost relate to consumer-level outcomes within EP programs?
5. What are the EP program components associated with consumer-level short- and long-term outcomes in particular domains?
6. Within EP programs, what program components lead to more or less utilization (e.g. hospitalization)?
7. To what extent do California EP programs deliver high fidelity to evidence-based care, and is fidelity related to consumer-level outcomes?
8. What are the barriers and facilitators to implementing a LHCN app across EP services?
9. What are the consumer, family and provider experiences of submitting and utilizing data obtained through the LHCN during routine clinical care?
10. Does a technology-based LHCN increase use of consumer-level data in care planning relative to a program's prior practice?
11. Does use of consumer-level data increase consumer insight into treatment needs, promote alliance with the treatment team, or improve satisfaction with care?
12. What will be a viable strategy to implement a statewide LHCN for EP programs?

Data collection and analysis for the LHCN evaluation will take place in multiple stages throughout the 5-year project (**see pg. 19 of Collaborative plan**). UC Davis and partners will be responsible for data analysis and writing the final evaluation report.
Taken together, this evaluation plan is a strong approach that will provide counties with rich data to determine the impact of EP programming on consumer-level outcomes.

Additionally, with the use of process and fidelity data received, the evaluation will also support the development and strengthening of EP programs within counties and statewide, as well as cross-county collaboration. **While the findings from the evaluation may provide an extensive amount of beneficial information, the dissemination activities that will take place at the conclusion of the project are not established**. **The Collaborative may wish to discuss how evaluation findings and lessons learned will be shared and disseminated**.

The Commission may wish to discuss how this project, if successful, may lead to the creation of a technical assistance center or data-clearing house for Early Psychosis programs similar to the California Child Welfare Indicators Project (CCWIP). CCWIP is a collaborative between the University of California at Berkeley and the California Department of Social Services and provides direct access to customizable information on California's entire child welfare system (California Child Welfare).

Privacy and Data

Data Storage and Access

Stakeholders have raised concerns about privacy and the security of data collected by applications proposed in previous innovation projects. Numerous news articles also raise concerns about data breaches and how data can be used. The Collaborative asserts that there are two main levels of data review intended for this project.

The first level follows standard practice in each county with the individual participant consenting to treatment through the county intake process. Consumers and providers will have access to all PHI information typically available in a clinic setting. Program management will be able to see a summary of all consumers in the clinic and compare to the California average.

The next level of review is data that is shared between clinics and the Contractor, UC Davis. To protect privacy UC Davis asserts that, "any data that is shared with UC Davis will have all PHI…identifiers removed except for zip code. We will work to ensure that we have enough demographic information to do meaningful analysis, but avoid combinations of PHI that could identify the individual" (**see page 17 of full plan**). UC Davis goes on to explain that each County will assign a unique participant ID for each consumer that only the County and EP Program will be able to link the participant ID with a specific person. This level of access will allow the Contractor to access de-identified data across all clinics for analysis.

The program level data will be acquired from participants in each clinic setting on a software application and dashboard which will be modified specifically for the program and county needs. The Collaborative is contracting with Quorum to modify the previously developed platform named MOBI. The Contractor reports that they have previous experience in implementing this type of technology in the UC Davis Early Psychosis Programs and has found that health software applications are useful to both consumers and providers to assess and monitor consumer outcomes of interest. The Contractor further states that the software application and web-based dashboard will be developed

with all appropriate protections for consumer information according to the Health Insurance Portability and Accountability Act.

Shared data will be stored at UC Davis, UCSF and UCSD and only accessible by the Contractor and sub-contractors (the study investigators and primary research team).

The Collaborative provides limited information on the data security in place for the online data collection system and the MOBI platform. **The Commission may wish to ask the Collaborative to discuss protections in place for data that is uploaded and stored as well as who has access to the data stored online, and how data will be segregated between counties.**

Institutional Review Board (IRB)/Coordination of the IRB Process
The contractor, UC Davis, states that IRB preparation and submission will occur in the first half of year one with approval expected in the second half of the first year.

County Specific Regulatory Requirements

Cultural Competency and Community Planning Process
Los Angeles, Orange, San Diego, and Solano Counties each demonstrated that this project was reviewed and supported by their communities through a local community planning process. For example, Los Angeles County sought feedback on this project on two separate occasions from their stakeholder body, the System Leadership Team, with representatives from diverse communities and stakeholders throughout Los Angeles County. Solano County held multiple comprehensive community stakeholder processes that included input from a diverse representation of stakeholders including consumers, family members, mental health and physical health providers, law enforcement, community organizations, educational community, veterans, and representatives from the County's unserved/underserved Latino, Filipino and the LGBTQ communities.

Through a contract with the MHSOAC from July-November 2018, the Contractor, UC Davis, worked to engage stakeholders, including clients served by EP programs and their families, the leadership and clinical providers within EP programs, county and state leadership, as well as community organizations in the development of this proposal.

The Collaborative reports that the proposed project follows a policy of 'nothing about us without us', including community stakeholder involvement at all levels of the project.

They state that meaningful engagement helped to create this proposal including the structure of the LHCN, outcomes to be included, and the evaluation approach.

Of particular note, the qualitative component of the proposed project will continue stakeholder engagement throughout the 3-year proposed project. The Collaborative is relying on participating stakeholders to guide them on how to best serve the diverse communities of each EP program.

In addition, the Collaborative will form an Advisory Committee after reaching out to engage diverse communities to ensure representation includes underserved populations.

The Collaborative also states that a standing agenda item of both project leadership and Advisory Committee meetings will be to ensure that this project is culturally sensitive and responsive.
The Collaborative expects that an outcome of the collaborative learning meetings between participating programs will address challenges and best practices in providing culturally responsive services. The Commission may be interested in hearing more about the culturally adaptive approaches currently in practice in EP programs at the county level.

The Budget

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	Contractor/ Evaluation	% for Evaluation	Sustainability Plan (Y/N)	Funds Subject to Reversion (Y/N)
Los Angeles	$4,545,027	$1,575,310	$2,969,717	65.34%	Y	Y
Orange	$2,499,120	$1,573,525	$925,595	37.04%	Y	
San Diego	$1,127,389	$201,794	$925,595	82.10%	Y	
Solano	$414,211	$291,399	$122,812	29.65%	Y	Y

Total	**$8,585,747**	**$3,642,028**	**$4,943,719**	**58%**

Los Angeles, Orange, San Diego, Solano counties are collectively contributing $8,585,747 of innovation dollars to fund the Early Psychosis Learning Health Care Network for five years.

UC Davis will receive $4,943,719 (58%) to manage the project, hire consultants, sub-contractors and complete the evaluation. Each participating county is paying a percentage of the contract with UC Davis based on the county size.

Los Angeles, San Diego, and Solano counties are contracting directly with UC Davis while Orange County will utilize the Joint Powers Authority, California Mental Health Services Authority (CalMHSA) as its fiscal intermediary with UC Davis.

Both Los Angeles County and Orange County are contributing additional “in kind” personnel support to the project.

In addition to County contributions, One Mind awarded UC Davis a $1.5 million grant to support this project. UC Davis utilized the grant to provide the necessary support to extend from a three year project to a five year project.

Stakeholder Feedback

All county plans were shared with MHSOAC stakeholders on October 16, 2018 and no letters of support or opposition were received. However, the MHSOAC did receive an email expressing interest in participating in the evaluation.

The Collaborative included five letters of support received from: Mental Health America; a family member of a person who experienced psychosis; a UCLA project consultant; the CEO of the identified contractor, Quorum Technologies; and the President of One Mind (**see appendix V in the original plan**).

Sustainability Plan
All Counties have indicated that they will incorporate lessons learned into existing programs to improve services. The Contractor will identify opportunities to self-sustain the Learning Health Care Network as part of this project.

Additional Regulatory Requirements
Commission staff have verified that this project is in line with MHSA general standards (**see page 22 of full plan**), including meeting expectations for cultural competency and stakeholder involvement.

All individual counties seeking to join the Learning Health Care Network appear to have met the minimum regulatory requirements listed under MHSA Innovation regulations.

If the Collaborative Innovation Project is approved, the MHSOAC must receive the certification of approval from Orange County and San Diego County's Board of Supervisors before any Innovation Funds can be spent.

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Full project proposals can be accessed here:

http://mhsoac.ca.gov/document/2018-10/early-psychosis-learning-health-care-network-statewide-collaborative-november-2018

Proposal Brief: Early Psychosis Learning Health Care Network Statewide Collaborative

Project Overview

A prolonged first episode of psychosis (FEP) without adequate treatment is the most consistent predictor of poor clinical and functional outcomes (Marshall et al., 2005), poor health outcomes (Gates, Killackey, Phillips, & Alvarez-Jimenez, 2015) and significant economic burden (Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005). Team-based "coordinated specialty care" (CSC) (Heinssen, Goldstein, & Azrin, 2014) for early psychosis (EP) has established effectiveness in promoting clinical and functional recovery (Kane et al., 2016). EP treatment programs have expanded rapidly with increased funding across the US without formal coordination of training or implementation. While EP programs share many features, the lack of state and national coordination and data infrastructure limits the capacity for large-scale evaluation or accelerated dissemination of best practices (Niendam et al., 2017). Based on prior collaborations with 30 California (CA) EP programs and experiences using mobile health (MOBI mHealth) technology to measure individual outcomes in EP care, the UC Davis (UCD) team is uniquely poised to create a CA Learning Healthcare Network (LHCN) that will contribute systematically collected outcomes data from individuals enrolled in CSC programs across 4 counties. Participating individuals will have experienced a first episode of psychotic illness (FEP) or be at clinical high risk for psychosis (CHR).

In order to address the inherent challenges of implementation of an evaluation of EP programs across California, in 2015 the Mental Health Services Oversight and Accountability Commission (MHSOAC) commissioned UC Davis to develop a method to conduct a statewide evaluation of these services. Further, between 3/13/2018 and 8/27/2018, 34 consultations with EP program and county management staff were held across 13 California Counties to develop a collaborative evaluation project. In total, 53 staff members contributed to these consultations. Following the consultation process, it was determined that the main goals of proposed project are to reduce the experience of isolation currently felt by California EP programs, address disparities across programs as a method to improve standards of care, collect data to better understand impact of specific components of the EP care model, and use the centralized data collection process to participate in nationwide efforts to improve EP care. A major development over the course of this consultation was to change the initial project period from the planned 3-year timeline to 5 years to allow for a longer project development and data collection period. Another major component of this consultation period was identifying possible funding mechanisms within the counties to contribute to the collaborative.

The current project builds upon the findings, collaborations, and partnerships established since 2015 to propose the development of a sustainable learning healthcare network (LHCN) for California. Four counties (Los Angeles, Orange, San Diego, Solano), in collaboration with the UC Davis Behavioral Health Center of Excellence and One Mind, are seeking approval from the MHSOAC to use Innovation Funds to develop the infrastructure for a sustainable LHCN for EP programs, the utility of which will be tested through a robust statewide evaluation. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and a number of California counties, will bring consumer-level data to the clinician's fingertips, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US. The evaluation would assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs. This will allow counties to adjust their programs based on lessons learned through multiple research approaches. One Mind, a foundation focused on improving brain health outcomes, has partnered in this project to enhance available resource to support achievement of project goals in a timely fashion.

The proposed Innovation project seeks to make a change to an existing practice in the field of mental health in order to increase the quality of services, including measurable outcome by:

1) Developing an EP learning health care network (LHCN) software application (app) to support ongoing data-driven learning and program development across the state
2) Utilizing a collaborative statewide evaluation to:
    a. Examine the impact of the LHCN on the EP care network
    b. Evaluate the effect of EP programs on the consumer- and program-level outcomes.

Purpose of Brief:

This brief provides additional information on aspects of the LHCN that were not well described in the previously submitted proposal. We provide these details here to give additional clarity in particular areas, including the framework and data security features of the MOBI mHealth application, data monitoring plan, and dissemination plan.

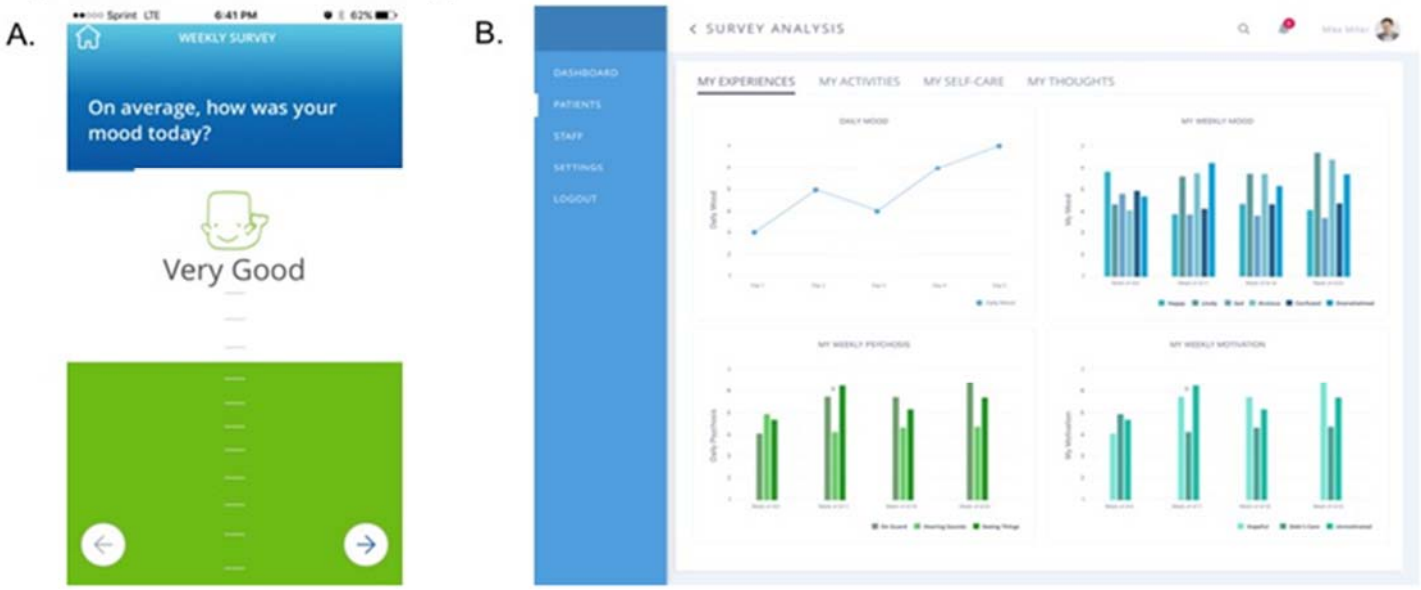
MOBI mHealth Network Application

Experts stress the need for measurement-based healthcare (J Fortney et al., 2015; Medicine, 2013) to improve client outcomes, enhance provider growth, and yield program improvement (JC Fortney et al., 2017). However, measurement-based care is not standard practice in mental health settings (Waldrop & McGuinness, 2017) and research suggests that less than 50% of mental health providers use data to inform treatment decisions (Lewis et al., 2015), impeding system-wide goals to use data to improve client outcomes. To shift clinical practice, providers need sufficient motivation, training and support to implement measurement-based care in treatment sessions and care decisions (Scott & Lewis, 2015). Our prior work implementing mHealth technology in community settings has helped us develop successful strategies to address this important barrier to change.

EP program participation in our proposed project was facilitated by the technologically innovative component of the MOBI informatics infrastructure combined with web-based data visualization. Using the MOBI app, clients and family members/support persons will complete validated self-report outcomes from the core assessment battery via iPads at baseline, 6, 12, 18, and 24 months (Fig. 1a). Client data is then visualized in real-time on the secure web-based dashboard (Fig. 1b). MOBI facilitates data collection via mobile devices and does not provide diagnostic or treatment information to clients or providers.

Both clients and providers provided positive feedback on the MOBI user experience. EP clients stated that using MOBI to help monitor symptoms and clinical outcomes “encouraged me to take my medication more frequently” (16 yr FEP client), and helped them to keep “better track of symptoms and medication” (20 yr FEP client). EP providers stated that using MOBI allowed them to “see patient responses in real-time versus waiting until our monthly check in” (Psychiatric Nurse Practitioner) and facilitated discussions of “changes in sleep patterns, symptom fluctuations, and interactions with others” (Therapist).

Figure 1. MOBI mHealth App and Dashboard



Training & Standardization for Implementation:

To support implementation of measurement-based care in clinical practice, we utilized stakeholder feedback from prior studies (Kumar et al., 2018; Niendam et al., 2018; Savill et al., 2018) to create training for EP providers on how to use client data during treatment to illustrate client progress toward recovery and inform collaborative treatment planning (Scott & Lewis, 2015). Our prior work demonstrated the feasibility and validity of collecting self-report symptom/outcomes data via client-facing applications and incorporating it into ongoing EP care for monitoring clinical outcomes (Kumar et al., 2018; Niendam et al., 2018). Acceptability figures are also promising: 85% of providers and 66% of clients endorsed continued use of digital health technology as part of EP care (Kumar et al., 2018). Similarly, technology-facilitated psychosis screening in schools and community health centers demonstrates high levels of acceptability, with 75% of staff noting it did not increase their workload (Savill et al., 2018).

MOBI Informatics infrastructure & Data Visualization:

When a user (client, provider, clinic administrator) is registered in MOBI by the Clinic Administrator, the system assigns a unique 128-bit Global Universal Identifier number (GUID). Each user is also assigned a secure log on and password to access 1) the app to enter data or 2) the dashboard to view a pre-specified level of data. MOBI alerts EP program staff to collect client data at the baseline visit and every 6 months thereafter until the end of 24 month follow up. MOBI will alert providers to administer the tablet up to 1 week prior and 1 week after the due date to ensure timely data collection. MOBI moves the participant through each core assessment measure in a seamless and friendly environment.

At the Clinician level, each provider can see their list of clients by name and a blue flag indicates a client completed a recent outcome evaluation. When an EP provider selects a client's name to view the client's dashboard, MOBI records the date, time, and viewing duration with the provider's login ID. MOBI will prompt EP staff to indicate 1) if the data is viewed during a client session and 2) how the data was used as part of care, such as "followed up by phone" or "scheduled follow up appointment," or "no action taken." These data use metrics allow analysis on rates of adoption and level of implementation of MOBI in the proposed study.

At the Clinician and Clinic Administrator level, data can be visualized by outcome measure 1) across all clients and time points, to show individual patterns of change over time; and 2) as an average of all clients across time points. Within MOBI, a “CA Benchmark” is computed in real-time across all individuals/sites and visualized as a dashboard overlay (Sarikaya, Correll, Bartram, Tory, & Fisher, 2018), with graphical and analytical characterization of outcome distributions, including central tendencies, variation and outliers. This benchmark quickly summarizes network data for rapid examination, allowing EPI-CAL sites and the UCD hub to see individual- or site-level variation across outcome measures and enabling quick intervention for clients or sites who deviate from sample-level expectations. MOBI also provides metrics of data completion by client/provider to monitor for missing data and timeliness.

At the Super Administrator level, research staff at the hub site can only view de-identified individual data at sites by GUID. MOBI is programmed to remove pre-specified protected health information (PHI) variables including age, year of birth, race, ethnicity, sex, gender identification/sexual orientation, and zip code by GUID and site. GUIDs are visible on the Clinician and Clinic Administrator dashboards to allow linkage between identifiable and de-identified data, if needed. Super Administrators can also see data visualizations by client or by site across time points, and metrics of data completion by client, provider and site. All data are populated to an embedded MySql database. MOBI allows download of de-identified data (.csv format) according to specified requirements (e.g. specific dates, sites). To add a measure to MOBI, a data dictionary is created with input from software developers, data managers, researchers and biostatisticians to ensure appropriate for data structure. Data quality metrics are embedded within the database (e.g. codes for missing data; specifications of data type and numeric format to prevent erroneous inputs; automatic scoring when appropriate). Through careful attention to database development and execution, MOBI minimizes the need for data cleaning at the hub level, allowing data preparation for immediate analysis as required by the RFA.

Quorum Technologies Inc./xcube labs will support ongoing software development for MOBI, contracted to UCD. This contract will provide software and database developers to enhance the MOBI application to collect data across the new core assessment measures, build in alerts to prompt site staff to administer the tablets on time, and collect data on EP providers’ use of MOBI to aid clinical decision making. A data manager at UCD will collaborate with Quorum during the system modification process to ensure the integrity of the database according to pre-specifications, to monitor data as it is collected by sites to ensure data quality, and troubleshoot data collection processes to inform Quorum that correction is needed for errors as they arise.

Security and Data Integrity: Security is provided at the app and dashboard levels. For the app, SureLock software on the tablets will restrict access to the MOBI application only, preventing non-authorized use of the tablet for other purposes or access to tablet settings. Devices that are sanctioned for use for the application will communicate via encrypted channels to the dedicated HIPAA-compliant customer cloud database. All data-at-rest and data-in-transit to/from Amazon Workstation (AWS) Simple Storage Service (S3) Data Centers is encrypted using SSL or client-side encryption. Adherence to all HIPAA requirements will be accomplished by the appropriate external infrastructure and global Policies and Procedures for HIPAA and HITECH rules, including Access controls, Integrity controls, Audit controls, Password controls, and Transmission controls. Information entered in MOBI is transmitted to the standard, external-facing, HIPAA-compliant Amazon Virtual Private Cloud (Amazon VPC). The Amazon VPC platform allows: 1) Basic AWS Identity and Access Management (IAM) configuration; 2) Multi-AZ architecture with separate subnets for different application tiers and private (back-end) subnets for the application and database; 3) Amazon S3 buckets for secured retrieval; 4) Standard Amazon VPC security groups for Amazon Elastic Compute Cloud (Amazon EC2) instances and load balancers; 5) Three-tier Linux web application using Auto Scaling and Elastic Load Balancing; and 6) A secured bastion login host to facilitate command-line Secure Shell (SSH) access to EC2 instances for troubleshooting and systems administration activities. Server-Side Data Encryption is

managed via AWS S3 Managed Keys (SSE-S3) or AWS KMS-Managed Keys (SSE-KMS). MOBI technical support staff will be provided via *a* secure remote access tool with participant consent (See *Human Subjects* for details).

Data Monitoring Plan

All data will be reviewed *weekly* by the PI and project staff to ensure that no problems exist with recruitment or data acquisition. Furthermore, a detailed review of all data will be conducted *monthly* to ensure appropriate collection and storage and to identify any outliers indicative of data entry errors. We will carefully monitor any potential risk factors throughout the course of the study.

Dissemination Plan

The proposed study seeks to develop the LHCN system for rapid dissemination into community practice. Results of qualitative interviews will identify barriers and facilitator to MOBI adoption and implementation, as well as the training and supervision required to support EP program implementation. This information will be used to develop videos and other training materials that can be used to support wider implementation of MOBI across additional EP programs. The LHCN will allow counties to identify common challenges and “lessons learned” can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.

In particular, the creation of the LHCN will support development of the EP Training & Technical Assistance Collaborative. During the development of the LHCN, an additional seven counties (Kern, Marin, San Luis Obispo, Santa Barbara, Sacramento, San Mateo and Ventura) expressed an interest in taking part in the project; however, they were working to develop their EP program with new funding or did not have available funding to participate at that time. These counties expressed interest in participating in qualitative aspects of the proposal, with the hope of joining the collaboration at a later date once network is established. They reported being particularly interested in learning from the LHCN and developing methods for training and technical assistance in the future. This highlights the broader interest by CA counties in the LHCN and supports the need for ongoing dissemination and engagement activities. UC Davis will survey counties and EP programs on a yearly basis to determine ongoing interest in joining the LHCN and how best to share information with them. For example, findings from the evaluation will be communicated with local and national stakeholders via BHCOE-supported webinars, 1-page briefs, or larger presentations based on the needs of the stakeholders. These will focus on providing information to consumer and family stakeholders, as well as local mental health practitioners. Other products from this project (e.g. webinars, written products, presentations) will be made available on the UC Davis Behavioral Health Center of Excellence (BHCOE) website (https://behavioralhealth.ucdavis.edu/events). The BHCOE has a regular public lecture series and, as results of the study become available, we will present a minimum of 2 lectures on study results in this forum.

Additionally, we will communicate the results of this project via publication in peer-reviewed academic journals or presented at conferences to share our findings with the larger community.

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AGENDA ITEM 6

Information

November 14, 2018 Commission Meeting

Legislative Priorities

Summary: The Commission will discuss opportunities and identify priorities for the 2019 legislative session.

Facilitator: Toby Ewing, Executive Director

Enclosures: None

Handout: None

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AGENDA ITEM 7

Information

November 14, 2018 Commission Meeting

Innovation Incubator Update

Summary:
In 2017, the Commission directed staff to develop a proposal for an Innovation Incubator to address the following four goals:

1. **Provide Strategic Guidance**. The Innovation component of the MHSA provides an opportunity to explore new ways to organize and deliver mental health services. An Innovation Incubator can allow the state to support innovation investments that target high-priority needs, facilitate multi-county collaborative to address shared challenges and build the evidence base to support systemic improvements in care.
2. **Support Technical Assistance and Training**. Innovation is difficult. To support the ability of counties to successfully plan, design and implement mental health innovations, the Incubator can help the counties tap California's broad innovation sector to support the goals of the MHSA.
3. **Enhance Evaluation**. Program evaluation is a key component of the MHSA Innovation component. The Incubator can support the design and delivery of evaluations that can help the counties and other stakeholders understand the impact of individual innovations and the broad innovation component.
4. **Disseminate Information**. For innovations to lead to transformational change, the lessons learned need to extend beyond the individual counties that invested in the initial innovation. The Incubator can help capture the lessons learned from the Innovation component and translate that information into systemic change necessary for statewide impact.

The Commission has received Expenditure authority to spend $5 million to launch an Innovation Incubator. The Commission's budget includes $2.5 million in Fiscal Year 2018-19 and $2.5 million in 2019-20. The Administration has directed that these funds be dedicated to strategies that have the potential to reduce the number of mental health consumers who become involved with the criminal justice system.

The Commission retained California Forward and X-Sector Labs to develop a business plan for the innovation incubator.

From April to October 2018, the Commission, in partnership with California Forward and X-Sector Labs, convened a series of stakeholder meetings and Design Labs to explore the necessary functions of an innovation incubator, build a business plan and develop criteria for the management of an

organization or strategy that can support mental health innovation in California.

As a result of that work, please see the attached DRAFT Business Plan for Commission comment. The plan includes three distinct components:

1. **Developing an Innovation Roadmap**: The Commission staff continue to work on the internal process for review and approval of County Innovation plans. Stakeholders and counties have highlighted the opportunity to further refine this process. Commission staff recommend utilizing the Innovation Subcommittee to determine (1) the clear definition of Innovation and the criteria for the approval of innovation plans (2) a consent process, and (3) a plan to utilize the Innovation Incubator as a way to "certify" the proposal as meeting Commission criteria and be eligible for the consent process.
2. **Build a Learning Community**: In consultation with counties and other experts, there has been a need for a broader level of technical assistance and a clearinghouse of information and data to support the system. For example, through the work of the Schools and Mental Health Initiative, we've learned that the Centers of Excellence have provided an opportunity to support counties in their development of programming in schools through this type of information sharing. The Commission should consider these opportunities to further enforce the dissemination of information and learning.
3. **Establish an Innovation Incubator:** Consistent with the budget authority referenced above, the Commission is authorized to launch an Innovation Incubator. The design process described above defined some roles for the incubator that included, multi-county collaborations, technical assistance to counties, training, and guidance on evaluation and the dissemination of lessons learned.

The Commission was provided a copy of the DRAFT Business plan during the July and August Commission Meetings.

The next step is to take the conceptual proposal and consider the following:

1. Building upon the final business plan proposal and with additional stakeholder engagement, the Commission could use a Request for Proposal (RFP) or a Request for Concept Proposal (RFCP) to establish the Innovation Incubator. Given the unique nature of this proposal, what would the Commission see as the appropriate for the procurement process?
2. Given the number of elements and options for the Incubator (University, non-profits), there is a need for more consulting with state procurement experts and a public outreach process for proposals to understand what is available and how to build the framework of the procurement process.
3. Once the guidelines and the procurement process are developed, staff plans to return to the Commission for review and approval of this process and suggested timeline in either January or February 2019.

Based on feedback and guidance received, we will continue our work with the consultants and support further stakeholder involvement.

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

Enclosures (1): Draft Business Plan

Proposed Motion: None.

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MHSOAC Innovation Incubator – For Commissioners' November 2018 Meeting

Executive Summary

Ensuring access to appropriate and effective mental health services is a challenge that touches on health, safety, education, housing, and the economic and social needs of millions of Californians, their families and our communities. This challenge presents a golden opportunity to leverage innovation to transform how we approach mental health by focusing on prevention, early intervention, recovery and outcomes that promote health, safety, independence and opportunity.

The goal of innovation should not just be to serve more people, but to serve people better. The focus of innovation should not just be to expand interventions, but to transform processes, policies, regulations and systems to remove barriers getting in the way of success. The role of county behavioral health departments should not just be direct service, but to collaborate with and empower cross-sector partners to expand reach and impact. The measured outcomes of mental health services should not just be number of people served, but sustained reduction of homelessness, incarceration, suicide, and unemployment.

The Innovation Incubator has the potential to transform and improve the efficiency of the mental and behavioral health system to become more consumer-centric and data-driven, while focusing on community engagement, quality improvement, and capacity building.

Five key problems have been consistently identified during the facilitated discussions with more than 100 members of the mental and behavioral health field, including behavioral health directors, county and statewide staff, academics and researchers, human-centered design experts, business leaders and entrepreneurs, service providers and practitioners, stakeholders and advocates, and consumers and family members[i]:

1. Stakeholders at every level expressed frustration that the current state of innovation is not meeting its promise of being a driver of transformational change, often pointing to the structural, regulatory, and systemic barriers of government.
2. Consumers, family members, and other community members often feel disconnected from Counties' innovation processes and that their needs are not being met.
3. Stakeholders at every level expressed frustration that there's a lack of a clear definition of transformational innovation, and some county behavioral health departments find it challenging to get their innovation projects approved by the Commission due to the opaque requirements.
4. Many county behavioral health departments find it challenging to identify, implement, and robustly evaluate truly innovative projects.

5. Many county behavioral health departments find it challenging to learn from each other's experiences and discover applicable ideas and practices from other fields and industries.

The following changes could address these problems:

1. A cultural shift that would encourage, support and rewards experimentation and learning could benefit stakeholders at every level.
2. Regular and continuous engagement between behavioral health departments, consumers, and family members at every point in the innovation process, from identifying needs and data gathering to prototyping and scaling, could create better solutions and generate more positive impact.
3. Clarifying what transformational innovation looks like, how proposals are evaluated, and how the Commission prioritizes and makes final funding decisions could improve the innovation approval process.
4. A deeper understanding of how to engage in a transformational innovation process, from identifying needs and data gathering to prototyping and scaling, could benefit behavioral health departments.
5. Creating a way to access data and learnings across counties to more efficiently and effectively address problems and design solutions could benefit the entire mental health ecosystem and improve outcomes.
6. Being able to work with a cross-sectoral team that can help engage and leverage the necessary knowledge, skills, and resources to effectively and efficiently drive innovation could benefit local government staff and elected officials.

The following solutions could effectively deliver these desired changes:

1. Assemble a cross-sectoral cohort of leaders across counties who are well-trained in innovation processes to be advocates for and drivers of innovation, responsible for "reimagining the system," and finding better ways to approach and solve problems
2. Establish processes for engaging consumers and family members, including incentives for data gathering and training in human centered design and empathy interviews
3. Offer a clear definition of and roadmap for transformational innovation and provide behavioral health departments with guidelines to use in evaluating the features of their innovation processes and desired outcomes
4. Offer county departments the option to train employees on the innovation process, and/or use a la carte consulting services that can aid in the process as needed
5. Create an online clearinghouse to share information across California with a community of learners comprised of county professionals, service providers, entrepreneurs, researchers, advocates and consumers. This community can access actionable data and examples that can inform the innovation process and identify gaps in the system that can be addressed.
6. Establish "Challenges and Design Competitions" where entities submit specific problems that they're struggling to solve, inviting cross-sector collaborations across

the state to design solutions in exchange for monetary incentives, technical assistance, and prizes

These solutions form the foundation of an **Innovation Ecosystem**. The Innovation Ecosystem will leverage the resources, organizations, and partners that already exist in the field while also building additional services as needed to support behavioral health departments, service providers and stakeholders. There are three key components of an Innovation Ecosystem:

1) **Innovation Roadmap** – providing a clear definition of what processes and capacities are essential to foster transformational innovation, and provide criteria for Commissioners to approve, reject or require additional action for counties to receive an approval to expend innovation funds

2) **Learning Community** – building an online clearinghouse of information and a community of researchers and practitioners, issue-specific task forces, and a series of virtual and in-person events to disseminate data and stories on challenges and progress throughout the field of mental and behavioral health

3) **Innovation Incubator** – creating an entity that will help behavioral health departments work collectively to develop partnerships within their communities and among counties, secure technical assistance and connect the incubation process with the formal community planning process, design and implement better community engagement strategies, evaluate projects and emerging practices to encourage replication and continuous improvement, and disseminate information on challenges and progress through a community of practice. The Incubator will have two key products and services:

    a) **Technical Assistance Services** – providing backbone support and a la carte training, capacity building, and consulting services to county-led collaborations and/or Learning Community members to improve innovation capacity and drive measurable outcomes

    b) **Issue-Specific Challenges and Design Competitions** – a Learning Community task force (or potentially other funders) could develop an "investment thesis" based on county-specific and statewide needs, and issues an RFP to attract local collaborations that desire incubator services and participating in a statewide and cross-sector Community of Practice

Summary of Observations and Insights
What we've heard, where we need to go, and how to get there

Across all five design labs, two stakeholder meetings, and dozens of interviews, we've heard five key problems emerge, and begun to flesh out what needs to change, and how to get there:

Stakeholders at every level expressed frustration that the current state of innovation is not meeting its promise of being a driver of transformational change. While it was noted innovation is happening in pockets across the state, it was also stated that there is not enough of it, examples are not widely visible or supported. Often pointing to the structural, regulatory, and systemic barriers of government, stakeholders across Design Labs expressed that the incentives, cultures, and workflows that exist within their organizations tend to inhibit, rather than support the experimentation and exploration that is necessary for fostering innovation. A common lack of tolerance for failure, fear of change, and comfort with the status quo, alongside minimal incentives for innovative approaches were all described as contributing factors.

> *Where we need to be:* A cultural shift that would encourage, support and rewards experimentation and learning could benefit stakeholders at every level.
>
> *How to get there:* Assemble a group of people across counties who are well-trained in innovation processes to be advocates for and drivers of innovation, responsible for "reimagining the system," and finding better ways to approach and solve problems.

Consumers, family members, and other community members often feel disconnected from Counties' innovation processes and that their needs are not being met. It was clear that many of the existing process that helps identify needs and proposes solutions was largely disconnected from consumers and family members. Needs are often driven by identifying areas that were costing the county the most amount of money, rather than determining the most systemic root causes. Solutions generation often happened in a vacuum, without prototyping, testing, and iterating the solution with consumers before launching it. This has resulted in programs that are often inefficient or ineffective at addressing the problem due to mismatch with true problems and/or lack of appeal to consumers.

> *Where we need to be:* Regular and continuous engagement between behavioral health departments, consumers, and family members at every point in the innovation process, from identifying needs and data gathering to prototyping and scaling, could create better solutions and generate more positive impact.
>
> *How to get there:* Establish processes for engaging with consumers and family members, including encouraging continuous data gathering and providing training in human centered design and empathy interviews. Communities should also have a team of dedicated "cultural brokers" who are especially skilled in these areas. These

brokers can be responsible for sourcing and understanding needs in the community, identifying consumers and family members to engage throughout the process, and being an active conduit between communities and the innovation teams throughout the design process.

Stakeholders at every level expressed frustration that there's a lack of a clear definition of transformational innovation, and some county behavioral health departments find it challenging to get their innovation projects approved by the Commission. Many stakeholders are frustrated by the lack of clarity from the Commission of what transformational innovation is - both when it comes to the process required to arrive at it and the assessment of proposed projects and solutions. Many behavioral health departments and stakeholders are also frustrated by the time it takes to move a proposal through the process (both local and with MHSOAC) to get assessed and approved.

Where we need to be: Clarifying what transformational innovation looks like, how proposals are evaluated, and how the Commission prioritizes and makes final funding decisions could improve the innovation approval process.

How to get there: Offer a clear definition of transformational innovation and provide behavioral health departments with guidelines to use in evaluating the features of their innovation processes and desired outcomes

Many county behavioral health departments find it challenging to identify, implement, and robustly evaluate truly innovative projects. The processes county staff undergo when it comes to problem identification, solution design, implementation, quality improvement, and evaluation could be more thorough and systematic. This has resulted in inefficiencies in discovering true community needs, a tendency to conduct a shallow assessment, focusing on "shiny, new" challenges raised by elected and appointed leaders, and identification of "quick fix" solutions (often expanding existing programs that only address the symptoms of the problem rather than the root cause). This is often due to a lack of capacity that adversely impacts the quality and quantity of innovation.

Where we need to be: A deeper understanding of how to engage in a transformational innovation process, from identifying needs and data gathering to prototyping and scaling, could benefit behavioral health departments.

How to get there: Offer county departments the option to either train employees on the innovation process, and/or use a la carte consulting services that can aid in the process as needed.

Many county behavioral health departments find it challenging to learn from each other's experiences and discover applicable ideas and practices from other fields and industries. Stakeholders have minimal established processes, frameworks or locations for sharing and sourcing data and "best practices" with each other. This realization has highlighted inefficiencies that arise because of constantly "reinventing the wheel." Additionally, agencies are often disconnected from the resources and knowledge

available outside the government, specifically business and technology. It was clear across labs that they appreciated the valuable role they could play in the innovation process and were interested in engaging with them. However, there is a lack of knowledge of exactly what value they could offer, how to engage them, and how their processes and interests could align. In addition to wanting to tap into industry-specific expertise, there was also interest in finding ways to engage in democratizing the innovation process and soliciting input from the broader community.

Where we need to be: Creating a way to access data and learnings across counties to more efficiently and effectively address problems and design solutions could benefit the entire mental health ecosystem and improve outcomes. Being able to work with a cross-sectoral team (including public, private, and nonprofit sectors as well as members of multiple departments and agencies) that can help engage and leverage the necessary knowledge, skills, and resources to effectively and efficiently drive innovation could benefit local government staff and elected officials.

How to get there: Create an online clearinghouse to share information across California (e.g. reports, studies, stories, successes, failures, proposals, and relevant articles on where other counties, service providers and researchers have succeeded, failed and learned from) so they can access actionable data that can inform the innovation process. Establish a cross-sector community of leaders, where they can interact through facilitated conferences and meetings and participate on task forces about specific topic areas based on specialty and interest. Establish "Issue-Specific Challenges and Design Competitions" where entities submit a specific problem that they're struggling to solve and invites experts and community-members across the state to design collaborative solutions.

Landscape Review and Analysis[ii]

Why Incubators are Important

Incubators provide innovators and entrepreneurs access to the critical resources they need to launch scalable and sustainable products, services, and solutions. The resources provided by incubators vary broadly, but can include knowledge, training, expertise, funding, physical resources (such as space), network, and human capital.

Incubators span across sectors, areas of focus, and stage of initiative. There are incubators in for-profit, nonprofit, government and academic settings. They can focus on launching startups, building specific initiatives within an organization, teaching the principles of innovation, facilitating connections across sectors or communities, or a combination of these elements. They can work with individuals and organizations in identifying problems, designing solutions (prototyping, testing, refining), scaling an existing solution, or a combination of these stages. Incubators can also work with individuals, teams of individuals or entire organizations.

No matter the nature of the problem, stage of the solution, or context in which the innovation is being launched, without an incubator these resources and opportunities are typically otherwise unattainable by innovators and entrepreneurs due to cost, lack of expertise, and/or access constraints inherent in designing and testing a new innovation. Therefore, by gaining access to incubators and their associated benefits, innovators can more effectively and efficiently deliver and scale products and services to their target user and maximize the potential impact on the problem-to-be-solved.

What does the mental and behavioral health field stand to gain from an incubator?

Stakeholders at every level, including county behavioral health departments, stand to gain a tremendous amount from implementing an incubator that is tailored to address the unique, intricate, and complex processes inherent in implementing and scaling innovation both locally and statewide. By gathering the necessary resources (physical, monetary and human) and suite of services, counties will become empowered to more effectively and efficiently address the mental health challenges that are currently unaddressed, misaddressed, or underserved under the current solutions. If done right, and with appropriate evaluation, these solutions will not only reach more people and deliver superior results but can also do so in a more cost-efficient manner.

How do incubators work across sectors?

In order to design the most effective incubator to address the unique challenges of the counties and state, we conducted an extensive landscape review of the various incubator business models. While there are several business models not represented, the examples below represent those we believe are the most relevant within this context.

Lab@OPM (federal government hosted and funded)

The Innovation Lab at the Office of Personnel Management (Lab@OPM) is a program run by human-centered design experts from the Office of Personnel Management who partner with government organizations looking to design innovative solutions for their most

complex problems. The core function of the Lab is to build the Federal Government's innovation capacity by training existing employees across organizations on how to effectively innovate by taking a human-centered design approach to solve problems. Depending on the project, this could include providing technical assistance to help on user experience design, service design, product design, program design, policy design, design strategy and/or design research. The Lab also offers community-building initiatives aimed to bring innovators together to share insights through an innovators network, thought leader talks, monthly education products, and publications. It also conducts and disseminates applied research around how to adapt design methodologies to address the unique processes and challenges of Federal Government organizations. Two of the notable partners that the Lab has engaged in government are 18F and the United States Digital Service (both of which are organizations that leverage private sector professionals to partner within government to build and scale solutions) to implement wide scale cultural change to better support innovation within government.

Challenge.gov (government clearinghouse)
Challenge.gov is an online platform on which agencies across the federal government can post and run various challenge and prize competitions that solicit ideas and solutions from the public in exchange for monetary rewards. The goal of the program is to engage the broader public in public sector problem solving and infuse a diversity of new ideas and approaches into problems the government lacks the knowledge, expertise and/or resources to efficiently or effectively address. The initiative was launched in 2010 after the White House's Strategy for American Innovation urged agencies to increase their ability to promote innovation with tools such as prizes and challenges. Since its launch in 2010, over 825 challenges have been run, over $250 million in prize money has been awarded, over 250K problem solvers from over 180 congressional districts have engaged, and over 5 million people from every state in the US (and several countries across the globe) have engaged with the website.

San Francisco's Entrepreneurship in Residence (EIR) Program (government and for profit)
San rancisco's EIR Program brought in teams of entrepreneurs to work alongside city officials for 16 weeks on addressing specific challenges and designing more effective public-sector initiatives. The program was started in 2013 in an effort to bring new ideas and innovative tech approaches to the city and give entrepreneurs a chance to enter the public-sector market (there was a lot of demonstrated interest, but lack of awareness of opportunities to productively engage). Teams of entrepreneurs applied and were chosen based on their demonstrated capacity to address a relevant issue, and plan to create a solution with at least $100m worth of economic potential that could be scaled to meet the needs of other cities or municipalities. Projects of the EIRs included things like: finding ways to more efficiently leverage open data, better utilizing public assets, improving healthcare, and improving the transportation system. A similar program was started by the US Citizenship and Immigration Services Department.

Stanford d.school (academic hosted, multi-sector funded)
The Stanford "d.school" (Design School) offers a variety of courses and programs designed to teach students within and beyond the Stanford campus how to use design thinking tools

and methodologies to identify and design innovative solutions to real world problems. They take the necessary steps to build scalable and sustainable products, services, and companies. While the options are widely variable in terms of application, audience, and duration, all of them have an educational component at the core of the curriculum. Two examples of programs offered by the d.school are Hacking for Defense, and the d.School Fellowship Programs:

- Hacking for Defense: Hacking for Defense (H4D) is a Stanford course run in partnership with the Department of Defense (DoD) and Intelligence Community (IC), designed to provide students the opportunity to learn how to work with the DoD and IC to better address the nation's emerging threats and security challenges. Students from across the graduate programs work in teams to design real solutions to real problems faced by the DoD and IC and have the potential to get follow-on funding for further refinement and development of prototypes so they can be applied in the field.
- d.School Fellowship Programs: *Project Fellowships* are granted to experts across fields who are passionate about innovating new solutions, platforms and initiatives within their respective fields. During the program, fellows use design thinking methodologies to actively conduct in-field experiments that have the potential to advance their field, or benefit the broader systems they operate, live and work within. The fellows are supported by the design thinking experts and incredible network the d.school affords. *Teaching Fellowships* are granted to people inside and outside the Stanford community looking to spend one year learning how to apply and teach the principles of design thinking. Teachers build courses, make connections, and build new design thinking methodologies.

New Ventures (international, for profit hosted, cross-sector projects, government funded)
New Ventures is an incubator based in Mexico that focuses on building and scaling social impact startups. The incubator is privately run by seasoned entrepreneurs and investors but raises funds from the Mexican government to invest in the participating startups. The Mexican government started the program because they needed more innovative solutions for government problems and wanted to support the startup ecosystem, but they didn't know how to effectively do so themselves. Each year, the government provides the incubator with an "investment thesis" or area of focus based on the most pressing governmental needs, and the incubator recruits entrepreneurs and startups that offer solutions for that problem (for example: energy, homelessness). Teams are taken through a defined 6-month curriculum (including: business, marketing, operations, human resources), offered a suite of resources (e.g. physical space), and are granted access to mentors and relevant experts across sectors to guide them through product development, testing, and implementation. At the end of the program, startups have the opportunity to pitch their company to raise government funding and are given access to highly favorable loans from the National Bank (otherwise very hard to secure for startups in Mexico). In addition to the incubator program, New Ventures also hosts a series of Grand Challenges, which solicit ideas and solutions from entrepreneurs and innovators across society to address specific problems in exchange for a financial reward. The program has been highly successful in generating innovative solutions to real government problems and fueling the startup ecosystem in Mexico.

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Y Combinator (learning community, for profit hosted and funded)

Y Combinator is a large, highly acclaimed incubator in Silicon Valley for startups. Y Combinator invests a small amount of money ($120K) into a highly selective cohort of startups in exchange for equity (6% of the company). Y Combinator teams participate in an intensive and immersive 3-month program during which they are guided through a training program and curriculum on how to design and scale their companies. For entrepreneurs, much of the value of the incubator comes from the unique access to a network of seasoned entrepreneurs, expert investors, domain experts, and Y Combinator Alumni who can provide specific, actionable, and strategic advice on how to address challenges and capitalize on opportunities across various aspects of the business. At the end of the program, startups participate in Demo Day, during which they pitch their business to Venture Capitalists and Angel investors in an effort to raise funding. In addition to training and network access, Y Combinator also provides other resources, such as physical space, human resource support, and other perks (e.g. advertising credits, free legal counsel). Y Combinator has been one of the most successful incubators, with over 1,700 alumni startups, a community of over 3,500 founders, and a combined valuation of $80B for participating startups. Some of the notable alumni include: Airbnb, Dropbox, Stripe, Reddit, Twitch, Coinbase, DoorDash, and InstaCart.

Proposed Innovation Ecosystem

1) Innovation Roadmap (Guidelines and Assessment)

Goal: Provide a clear definition of what processes and capacities are essential to foster transformational innovation, and provide criteria for Commissioners to approve, reject or require additional action for counties to receive an approval to expend innovation funds

A. Published Criteria and Rubric
B. Proposed DRAFT Categories and Standards
    a. Capacity for Innovation
        i. Innovation Process (sourcing needs, identifying root causes, solution generation, prototyping/experiments, going to market, learning culture/quality improvement, evaluation, scale/institutionalizing)
        ii. Organization Capacity of County (e.g. leadership, culture, staffing, dedicated resources, mandate/buy-in)
        iii. Community Engagement Process (beginning to end, stakeholder focus groups, consumer and family empathy interviews, engaging advocates)
    b. Capacity for Collaboration
        i. Capacity of Collaboration and Community of Practice (e.g. leadership, culture, staffing, dedicated resources, ability to be high performing team)
        ii. Diversity of Local Collaborators (composition of team, multi-sector, multi-department, demographic and stakeholder categories)
        iii. Diversity of Community of Practice (e.g. multi-county, multi-sector)
    c. Capacity for Learning and Potential for Impact
        i. Learning Culture and Quality Improvement (e.g. experimenting, testing, measuring, adapting, failing fast)
        ii. Evaluation and Research (improving social determinants/outcomes, ROI)
        iii. Systems and Process Improvement (driving systemic change)
        iv. Potential of Innovation (move needle on outcomes or systemic change)

2) Learning Community

Goal: Build an online clearinghouse of information and a community of researchers and practitioners, issue-specific task forces, and a series of virtual and in-person events to disseminate data and stories on challenges and progress throughout the field of mental and behavioral health

A. Membership
    a. Diverse members (multi-sector, multi-county, multi-department, academia, business, philanthropy, service providers, stakeholders, consumers, practitioners)
    b. Issue-specific communities
B. Products

a. Online Clearinghouse (well-designed repository of reports, studies, stories, successes, failures, proposals, and relevant articles)
b. Publications (newsletters, aggregated digests, journals, articles)
c. Events (conferences, webinars, award ceremonies)
d. Curated and robust database of partners in the ecosystem

C. Task Forces
a. Sponsors can create consortiums of members to focus on a specific issue area, policy, or component of the healthcare system
b. Findings of Task Forces could range from policy change to new Issue-Specific Challenges and Design Competitions for the incubator to explore (with pledged support from counties, foundations, and/or business)
c. Task Forces can also purchase Technical Assistance Services from Incubator
d. Policy and systems change will have a direct channel to commissioners, legislators, county superintendents and BHDs, and DHCS leadership

3) Innovation Incubator

Goal: Create an entity that will help behavioral health departments work collectively to develop partnerships within their communities and among counties, secure technical assistance and connect the incubation process with the formal community planning process, design and implement better community engagement strategies, evaluate projects and emerging practices to encourage replication and continuous improvement, and disseminate information on challenges and progress through a community of practice. The Incubator will have two key products and services:

A. Technical Assistance Services

Goal: Provide backbone support and a la carte training, capacity building, and consulting services to county-led collaborations and/or Learning Community members to improve innovation capacity and drive measurable outcomes

1. Training, Capacity Building, and Certification Services
a. **Innovation Process**– capacity building training will teach participants how to lead a team through an innovation process including sourcing needs from communities, identifying root causes of challenges, generating solutions, prototyping and experimenting, delivering services to consumers, creating a learning culture and process for quality improvement, evaluation, and scaling and institutionalizing. Successful completion will build internal capacity through a *Certified Innovation Ambassador*
b. **Community Engagement Process**– capacity building training will teach participants how to build an effective community engagement process from beginning to end, including assembling a diverse steering committee, conducting stakeholder focus groups, consumer and family empathy interviews, and engaging advocates. Successful completion will build internal capacity through a *Certified Engager*
c. **Capacity of Collaboration and Community of Practice**– capacity building training will teach participants how to build an effective cross sector

collaboration and innovative community of practice, including assessing and building leadership, trust, culture, managing power dynamics, and high performing teams. Successful completion will build internal capacity through a *Certified Collaborator*

d. **Capacity of County (or Organization)**– capacity building training will teach participants how to build an effective culture of innovation and collaboration within their organization, including assessing and building leadership and trust, changing culture, and supporting a high performing team. Successful completion will build internal capacity through a *Certified Innovator*
e. **Learning Culture and Quality Improvement**– capacity building training will teach participants how to build a flexible and learning culture, including effective experimenting, testing, measuring, adapting, failing fast, and driving for continuous quality improvement. Successful completion will build internal capacity through a *Certified Learner*

2. Consultative and Matchmaking Services
   a. **Evaluation and Research**– this consultative service will include assessing the evaluation and research plan including its focus on social determinants, mental health service outcomes, and measuring return on investment (ROI). The consultant will identify potential evaluators (people and organizations) who could enhance the research strategy and evaluation process. This matchmaking service may include seeking advice, support and connecting with Learning Community partners.
   b. **Diversity of Local Collaborators** and **Diversity of Community of Practice**– this consultative service will include assessing the diversity of local collaborators and communities of practice to identify what sectors and populations are being excluded. The consultant will work with key stakeholder groups to help identify potential *Cultural Brokers* (people and organizations) who could enhance the collaboration and be more inclusive. *Cultural Brokers* could also be trained to become *Certified Collaborators*. This matchmaking service may include seeking advice, support and matchmaking with subject matter experts from MHSOAC's stakeholder contractors.
   c. **Systems and Process Improvement** and **Potential of Innovation**– this consultative service will include assessing the innovation project's hypothesis on driving systemic change and its potential for innovation. The consultant will identify potential improvements and key performance indicators to ensure the innovation project has the potential to move needle on outcomes and/or systemic change.

B. Issue-Specific Challenges and Design Competitions

Goal: A Learning Community task force (or potentially other funders) could develop an "investment thesis" based on county-specific and statewide needs, and issue an RFP to attract local collaborations that desire incubator services and participating in a statewide and cross-sector Community of Practice

1. Request for Proposals
    a. **Incentives** – some challenges will have financial rewards (and/or matching funds) for local collaborations to compete for while others will just provide facilitation support by assembling a like-minded Community of Practice connected to paid incubator services
    b. **Acceptance** – all applicants will be assessed using the Innovation Roadmap Guidelines and the incubator will invite some or all of the applicants to join the Community of Practice, while ensuring readiness to innovate and diversity of approach and county size (ability to pay for incubator services may also be a criteria)

2. Community of Practice
    a. **Innovation Fellows** – 4-6 members of each county collaborative participates in cohort with monthly video calls and quarterly in-person sessions (they become *Certified Collaborator, Innovation Ambassador, Innovator(s), Engager, and Learner*)
    b. **Collective Learning** – Fellows learn from each other throughout the challenge and test hypotheses in multiple communities to advance learning
    c. **Disseminated Findings** – final solutions, lessons learned, what's working, and what needs additional investigation will be shared with Learning Community and can be pre-approved by MHSOAC (i.e. additional counties can get expedited approval for innovation funds so long as they follow Innovation Roadmap Guidelines and can show community interest and need)

3. Products and Services (tiered pricing based on county/population size)
    a. **Capacity Building** – Training, Coaching, Facilitation
        i. Access to Technical Assistance Services as needed
        ii. Every participating organization in a collaboration will need a *Certified Innovator*
        iii. Every collaboration will need at least one *Certified Collaborator, Certified Innovation Ambassador, Certified Engager, and Certified Learner*
    b. ***Collaboration Backbone***
        i. If collaborations do not have the resources or capacity to have a dedicated, experienced *Certified Collaborator* (or would like a coach for an inexperienced *Certified Collaborator*), they can request the services of a *Collaboration Backbone* to provide backbone support
        ii. *Collaboration Backbone*'s serve as imbedded consultants who offer support including, ensuring vision and strategy alignment, supporting aligned activities, sourcing community needs and building public will, identifying root causes, solution generation, prototyping and experimenting, mobilizing funding and take new products to market, fostering a learning culture and quality improvement, establishing shared measurement practices, and scaling results by advancing policy change. The duration of their engagement may vary depending on the needs of the initiative.

Proposed Business Model

All three of these components will be required to create an Innovation Ecosystem able to enhance and transform the mental and behavioral health field. However, each element may need a tailored business model.

1. **Innovation Roadmap**
   The MHSOAC clearly has the authority to provide a definition of innovation and criteria for Commissioners to approve, reject or require additional action for counties to receive MHSA innovation funds. However, we propose that the Commission engage county behavioral health directors and staff, stakeholder and advocacy groups (local and statewide), academic and research partners, technical assistance providers, service providers, and consumers and family members in a process to develop these criteria to create understanding and ownership. This would require building on the current definition and process while being willing to adapt and change based on feedback. Specifically, we propose that the development of these criteria be the first project of the Innovation Incubator. This element has the potential of aligning stakeholders and improving innovation throughout California at a low cost.

   Estimated cost: $100,000 - $250,000 for consultants, design labs, and stakeholder engagement and/or Innovation Incubator operator (plus MHSOAC staff time)

   Proposed payer: MHSOAC

2. **Learning Community**
   Building an online clearinghouse of information, community of researchers and practitioners, and issue-specific task forces would be a critical asset for the field of mental and behavioral health regardless of its connection to the Innovation Incubator. We propose that this component be pursued in parallel with building the Innovation Incubator, potentially in partnership with existing centers of excellence within California. We emphasize that the operator will need to both collect data and information as well as curate and foster an active cross-sector community.

   Estimated cost: $2 million - $4 million for first three years ($250,000-$500,000 for startup and operations plan (identify scope of information, format of clearinghouse, community curation needs, key partners and stakeholders, and potential paid membership model); $1 million - $2 million for launch; $250,000-$500,000 annually for active curation)

   Proposed payer: Seed funding from health-focused foundations with launch and ongoing operating costs from State of California and paid membership model

3. Innovation Incubator

The Innovation Incubation should support behavioral health departments in:

- working collectively to develop partnerships within communities and among counties
- securing technical assistance and connecting the incubation process with the formal community planning process
- designing and implementing better community engagement strategies
- evaluating projects and emerging practices to encourage replication and continuous improvement
- disseminating information on challenges and progress through a community of practice

The Incubator should be created by contracting with a new or existing organization that partners with existing technical assistance, research and quality improvement, and stakeholder and community engagement groups throughout California.

Beyond the technical assistance and design challenge services, the Incubator can provide coworking space where members of the Community of Practice can interact and collaborate with each other, *Collaboration Backbones*, *Imbedded Problem Solvers*, *Senior Fellows*, Learning Community members, incubator staff, and those coming into the Incubator for Technical Assistance training. This "hive" will be designed for creativity, cross-fertilization, innovation and serendipity. Membership to this coworking environment could be another revenue generating service to ensure financial sustainability.

We propose that the Incubator be launched with the $5 million in funds set forth by the Governor's budget in Y19-20. While we have proposed a model that is issue agnostic, the initial charge of the Incubator will be reducing the number of people deemed incompetent to stand trial (IST), as this is what is required by the source of funding. These funds will help launch the Incubator, covering startup and infrastructure costs, as well as an issue-specific challenge focused on IST. With the infrastructure built, additional issue areas can be addressed by the Incubator at a lower marginal cost.

Estimated cost: $5 million for first two years ($500,000 for startup costs, $1 million annually for facilities and administration, $1 million -$2 million annually for technical assistance, and $500,000-$1 million per challenge, assuming two to three challenges in first two years)

Proposed payer: Seed funding of $5 million provided by the State of California with a challenge focused on IST, additional funds from foundations and the State of

California could sponsor additional issue-specific challenges, and ongoing operating costs covered by county behavioral health departments (through MHSA Innovation funds and potentially other budgets) and other stakeholders paying for technical assistance services

Sustainability: All challenges are sponsored (either by State of California, foundations, and/or a consortium of county agencies), all technical assistance is paid for (either by county agencies, foundations supporting nonprofit or service provider capacity, and/or other stakeholders seeking services), and facilities and administration covered with an overhead charge on all challenges and technical assistance services

Proposed Model for Management and Operation

We identify the following three potential models for management and operation of the Incubator, and we propose that the MHSOAC pursue the Hybrid Model:

1. **Build from Scratch** – contract with an entity to build the Incubator with all of the essential services and staffing within a standalone organization
    a. Pros – customized for specified purpose and can become a one-stop shop
    b. Cons – most expensive model and doesn't leverage amazing work, past investment, and current excellence already taking place in the field
2. **Connect the Dots** – contract with an existing organization that functions as a curator to connect the current service providers in the mental and behavioral health field and those in need of technical assistance and consulting services
    a. Pros – least expensive model and leverages the best of what already exists
    b. Cons – relies on what already exists that are not currently meeting all needs
3. **Hybrid Model** – contract with a new or existing entity that builds a lean infrastructure that connects top service providers within the field and creates products and services missing within the mental and behavioral health field (e.g. design challenges, backbone support)
    a. Pros – reasonable cost, leverages the best of what already exists, and builds what is missing for the specified purpose
    b. Cons – will require extra time and resources to identify, source and, coordinate with existing service providers (including potential culture conflicts)

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Prototype for Executive Staffing of Hybrid Model

- CEO (Strategy and Business Development)
- CFO (or role absorbed from parent organization or fiscal sponsor)
- COO (Human Capital, Operations, Facilities)
    - F Learning Community Liaison
        - Network Weaver for connecting dots and encouraging engagement and quality contributions
    - F Training Faculty Lead
        - Assumes most trainings will be contracted out to approved vendors
    - F Consulting Lead
        - Matchmakers (*Senior Fellows*/Learning Community members)
        - *Collaboration Backbones* (potentially contracted out to approved vendors)
    - F Design Challenge Lead
        - Community of Practice Facilitator
        - Community Engagement Lead
        - Quality Improvement and Evaluation Lead
        - *Senior Fellows*– each challenge will assemble a select group of subject matter experts and former BHDs to support the Community of Practice
    - F Infrastructure Support
        - Analyst – to capture lessons learned, synthesize and advise on program improvements
        - Software engineer(s) – implement program improvements
        - Graphic designer
        - Facilities and events manager

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[i] **List of Organizations Engaged in Stakeholder Process**
7 Cups
Alameda County Behavioral Health Care Services
American Institutes for Research
Born This Way Foundation
Brainstorm: Stanford Lab for Brain Health Innovation and Entrepreneurship
Bring Change to Mind
CA Council of Community Behavioral Health Agencies
CA Pan-Ethnic Health Network
California Alliance of Child and Family Services
California Council of Community Behavioral Health Agencies
California Forward
California Health Care Foundation
California Institute for Behavioral Health Solutions
California Mental Health Services Authority
CBHDA
Center for theVulnerable Child, UCSF Benioff Children?s Hospital Oakland
CFLC Committee Members
Children Now
CLCC Committee Members

COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY
Consumer Advocates
Council on Criminal Justice and Behavioral Health
County of San Diego Health and Human Services Agency, Behavioral Health Services
County of Santa Clara
CPEHN
Depression & Bipolar Alliance
DHCS
DMH Los Angeles County
East Bay Agency for Children
Edegwood Center for Children and Families
former Citi Ventures
Fresno County
Health Access
Kern Behavioral Health and Recovery Services
Kern Behavioral Health and Recovery Services
Lincoln
Los Angeles County Department of Mental Health
Lucile Packard Chidlren's Hospital Stanford
MHALA
MHSOAC
Mindstrong Health
NextGen America
NorCAL MHA
OCHA
Open Source Wellness
Orange County Health Care Agency
Peers Envisioning and Engaging in Recovery Services (PEERS)
Prevention Institute
REMHDCO
Represents schools
San Bernardino County Behavioral Health
San Francisco Behavioral Health Services
San Francisco Department of Public Health
Santa Barbara County Department of Behavioral Wellness
Santa Clara county superior court
Seneca Family of Agencies
Social Interest Solutions
Stanford Psychiatry
Stanford University
Stanislaus County/Behavioral Health and Recovery Services
Steinberg Institute
Swords to Plowshares
TeenzTalk
The Lab at OPM
Third Sector Capital Partners
Transitions Clinic Network
U.S. Department of Labor
UC Davis Dept of Psychiatry
UCSF Children's Hospital Oakland
United Parents
Uplift Family Services
Walter S Johnson Foundation, administered by Whittier Trust
Young Minds Advocacy
Youth Tech Health

[ii] **List of Incubator Models Researched**
Grand Central Tech
NFX
InBIA
Department of Homeland Security's CyberApex Program
Seneca Family of Agencies
Entrepreneur First
Plug & Play
IDEO
Chobani Incubator
Tipping Point Community
Superpublic
Deloitte's reenhouse
Booz Allen Innovation Center
1776
City Innovate
Case Foundation
Techstars
Launchpad
Lean Launchpad
BioDesign
Omidyar Network
Emerson Collective
Presidio Institute
World Economic Forum
The Technology Suite (and 7 Cups)

Sources

- Singari Seshadri, *Associate Director, Entrepreneurial Programs Center for Entrepreneurial Studies, Stanford Graduate School of Business*
- Russell Siegelman, *Lecturer in Management, Stanford Graduate School of Business*
- Robert Chess, *Lecturer in Management, Stanford Graduate School of Business*
- Peter Reiss, *Lecturer in Management, Stanford Graduate School of Business*
- http://www.govtech.com/local/SF-Launches-Entrepreneurship-in-Residence-EIR-Program.html
- https://www.challenge.gov/
- https://lab.opm.gov/
- http://www.ycombinator.com/