December 17, 2018
PowerPoint Presentations and Handouts

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City of Berkeley MHSA Innovations Trauma Informed Care Plan Update

Presenting Problem/Need

- Children/youth who have been traumatized frequently “act out” through various behaviors often subjecting them to disciplinary actions which can re-traumatize or further traumatize them.
- The Trauma Informed Care Project (TIC) was approved by the MHSOAC in May 2016 for $180,000 through June 2018 to address trauma in children and youth within school and educational settings.
- The project was created to assess whether educators in several BUSD schools who are trained to become aware of their own trauma and trauma triggers are better equipped to recognize and make appropriate decisions on how to assist students who exhibit trauma symptoms.

Proposed INN Project to Address Need

- ***The TIC Project Made a change to existing TIC for Educators projects by:***

  - ✓ Implementing the project through an existing learning collaborative, the City of Berkeley's 20/20 Vision Program, that would stay involved in and provide support through "Peer Support Learning Circles"
  - ✓ Utilizing a "Train the Trainer" model
  - ✓ Focusing educator's recognition of their own trauma/trauma triggers as a conduit to better understanding youth acting out behaviors

  - ✓ Inviting parents to participate in the training to assist them in recognizing their children's, and their own, trauma and trauma triggers and in seeking supports.

Intended Outcomes/Learning Objectives

- To create a change in the way educators and school staff view and handle challenging student behaviors (which often mask trauma).

- To create an increase in access to mental health services and supports for students in need.

- To promote better student mental health outcomes by increasing referrals to “appropriate” mental health services.

Current Situation

- Original TIC Project was implemented for one year in FY2016/17, due to staffing vacancies.
- Once staffing was filled, the Schools no longer able to prioritize project due to additional mandatory training requirements.
- Program Manager found that although the schools could not participate, Head Start programs were interested in implementing the project.
- Through a letter to the MHSOAC, approval was obtained to extend the original project until June 30, 2021.

Modified TIC Project

- Change the population from BUSD School educators/students to Head Start educators/students
- Increase funding for project by $266,134.
- Apply the same Intended Outcomes/Learning Objectives as in the original project to the new population.

Innovation Budget

REQUESTED ADDITIONAL FUNDING FOR REMAINDER OF PROJECT				
A. EXPENDITURES				
Type of Expenditure	**FY 2019**	**FY 2020**	**FY 2021**	**TOTAL**
Personnel expenditures, including salaries, wages, and benefits	$9,833	$72,800	$54,600	$137,233
Operating expenditures	$0	$14,000	$10,000	$24,000
Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHSA duties to conduct the Innovative Project	$1,500	$6,825		$8,325
Contracts (Training Consultant Contracts)	$0*	$0*	$25,609	$25,609
Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures in the budget narrative (Costs for an Evaluator)	$5,000	$17,800	$14,500	$37,300
Total Direct Expenses	**$16,333**	**$111,425**	**$104,709**	**$232,467**
Indirect	$5,757	$17,010	$10,900	$33,667
Total Proposed Expenditures	**$22,090**	**$128,435**	**$115,609**	**$266,134**
MHSA Innovations Funds	$22,090	$128,435	$115,609	$226,134
Total Revenues	**$22,090**	**$128,435**	**$115,609**	**$226,134**
B. TOTAL ADDITIONAL FUNDING REQUESTED	**$58,090**	**$128,435**	**$115,609**	**$226,134**
***Previously approved and remaining $70,691 funds will be spent on the Training Consultant				
**If successful the City may evaluate other funding sources to sustain the Innovation project.				

CONTACT INFORMATION & RESOURCES

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City of Berkeley MHSA Website

www.ci.berkeley.ca.us/mentalhealth
*(follow link to MHSA webpage)

Proposed Motion

MHSOAC approves City of Berkeley's innovation project as follows:

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

REQUESTED BUDGET FOR TRAUMA INFORMED CARE PLAN UPDATE

The MHSOAC previously approved a budget of $180,000 for the original Trauma Informed Care Plan. Of that amount $109,309 has been expended, with $70,691 of remaining funds. The City of Berkeley is requesting to utilize the remaining $70,691 of previously approved funds, plus an additional $266,134 in new funds for a total budget amount of $336,825 for the Trauma Informed Care Plan Update. The funds will be utilized as follows:

A. BUDGET EXPENDITURES*					
	Type of Expenditure	**FY 2019**	**FY 2020**	**FY 2021**	**TOTAL**
1.	Personnel expenditures, including salaries, wages, and benefits	$30,333	$72,800	$54,600	$157,733
2.	Operating expenditures	$3,000	$14,000	$10,000	$27,000
3.	Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHSA duties to conduct the Innovative Project	$5,000	$6,825		$11,825
4.	Contracts (Training Consultant Contracts)	$9,000	$40,300	$20,000	$69,300
5.	Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures in the budget narrative (Costs for an Evaluator)	$5,000	$17,800	$14,500	$37,300
6.	**Total Direct Expenses**	$52,333	$151,725	$99,100	$303,158
7.	**Indirect**	$5,757	$17,010	$10,900	$33,667
	Total Proposed Expenditures	**$58,090**	**$168,735**	**$110,000**	$336,825
1.	MHSA Innovations Funds	$58,090	$168,735	$110,000	$336,825
	Total Revenues	**$58,090**	**$168,735**	**$110,000**	**$336,825**
B. TOTAL FUNDING REQUESTED		**$58,090**	**$168,735**	**$110,000**	**$336,825**

*Budget includes $70,691 of previously approved funds, and $266,134 of new funds.

BUDGET NARRATIVE

Personnel Expenditures: Costs for Project Manager and personnel with YMCA who will be directly implementing the project.

Operating Expenditures: Costs for infrastructure, administrative support, mileage, travel, office supplies, space and other common operating expenses for the project.

Contracts: Costs for contracts with Training Consultants

Non-recurring Expenditures: Costs for curriculum and IT required for the project.
Contracts - Training Consultant: Costs to utilize T2 Regional Center Trainers to train 2020 Vision Collaborative partners.

Other Expenditures: Planned costs for an outside independent evaluator for the project.

Statewide Learning Health Care Network and Evaluation of California's Early Psychosis Programs

Tracy Lacey, LMFT, Solano County
Tara Niendam, Ph.D., UC Davis
Mark Savill, Ph.D., UCSF
Debbie Innes-Gomberg, Ph.D., Los Angeles County

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BEHAVIORAL HEALTH CENTER OF EXCELLENCE

Early Intervention is key for Psychosis

- Influx of state (Prop 63 PEI, AB1315, SB1004) and federal (MH Block Grant) dollars has led to rapid development of early psychosis (EP) programs across California
  - 30 programs in 24 counties in 2017, with more starting each year

- Research consistently shows that intervention within 18 months of psychosis onset = better long term outcomes (Kane et al., 2016)
  - Reduced rates of suicide, hospitalization, incarceration, homelessness
  - Improved quality of life, social/family relationships, work and school functioning
  - Reduced costs of care for counties and state

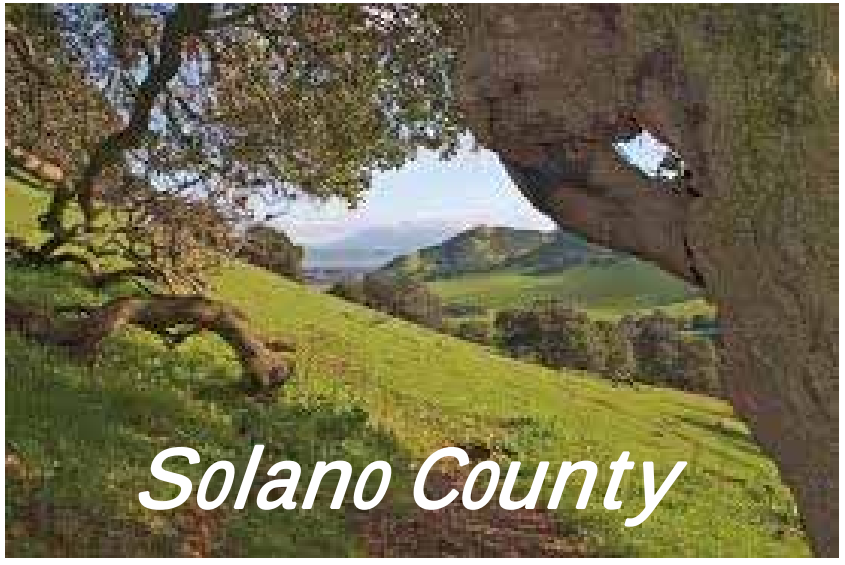
- Increased funding reduced disparities in access to and quality of care for all Californians - especially underserved and unserved individuals - across the state

Our challenge

- No uniformity across state in implementation of EP services – treatment models differ county by county
- No standard measurement of outcomes using valid and appropriate measures for EP populations
- Need to establish methods for implementing measurement-based care in community practice
- California EP programs are currently isolated from each other, and struggle to find training, resources or reduce staff turnover
- State and national initiatives are pushing for more collaboration and data sharing – and we need to respond.

Orange = 30 active EP programs

County Collaborative Effort



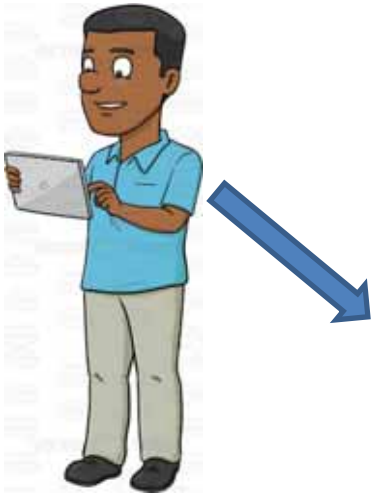
What is innovative about the proposed project?

Project will **make a change to an existing practice in the field of mental health** that will **increase the quality of services, including measurable outcomes.**

1. Creates a unified network of CA early psychosis programs to standardize practice and support knowledge-sharing
2. Harmonizes EP evaluation across core outcomes to enable large scale evaluation and program development
3. Achieve measurement-based care via EP-focused technology platform, enabling participation for consumers and families across 13 languages.
   - Collect and visualizes consumer-level data across a variety of recovery-oriented measures to empower consumers to use own data in care decisions
   - Provides immediate access to relevant outcome data for program leadership that can be quickly disseminated to stakeholders or shift program practice

Proposed Learning Healthcare Network for CA Mental Health programs

Consumer level



Consumer (and family) enter data on relevant survey tools (in threshold languages) in app-based platform at baseline and then regular follow up

Provider level

Clinician and/or MD can visualize responses on web-based portal for the individual over the course of treatment and share that data with the consumer during session.

Clinic level

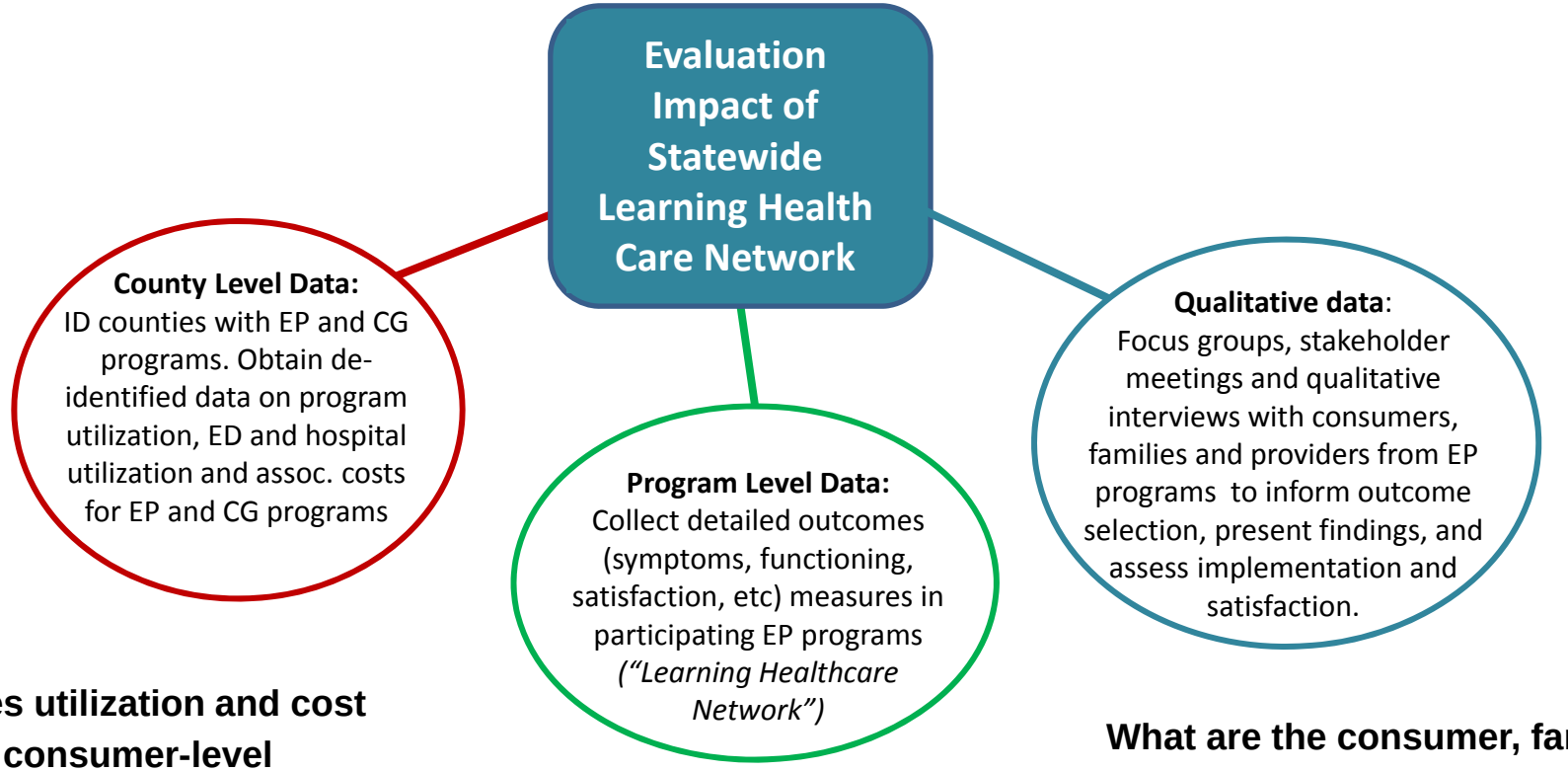
Program management can visualize summary of responses on portal for:
- All consumers in clinic
-In relation to CA average

State level

Administrator level allows access to de-identified data across all clinics on the app for analysis

Evaluating EP programs and Improving Care Outcomes

Learning Questions and Outcomes



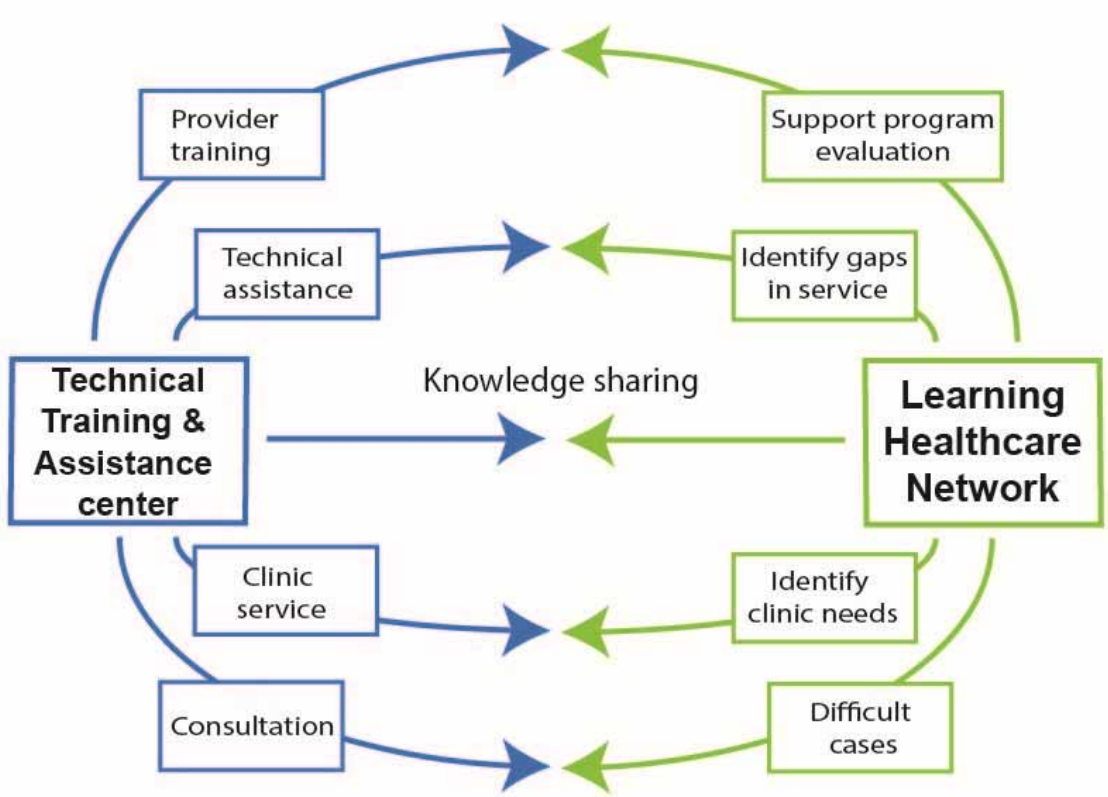
How does utilization and cost relate to consumer-level outcomes within EP programs?

What are the program components associated with consumer-level short-and long-term outcomes in particular domains?

What are the consumer, family and provider experiences of submitting and utilizing data obtained through the LHCN during clinical care?

Impact on California

The creation of the LHCN will support development of the EP Training & Technical Assistance Collaborative



Impact on California

Long Term Value:

- EP services are expanding across California – opportunity to create statewide approach to EP care
  - Springboard for SB1004

- Develop a <u>sustainable</u> learning health care network for California's EP programs, allowing consumers, families and the state to benefit from data and improve the quality of services across diverse communities.

- Enhance ability to participate and learn from national network of EP programs and data systems (EPI-NET).

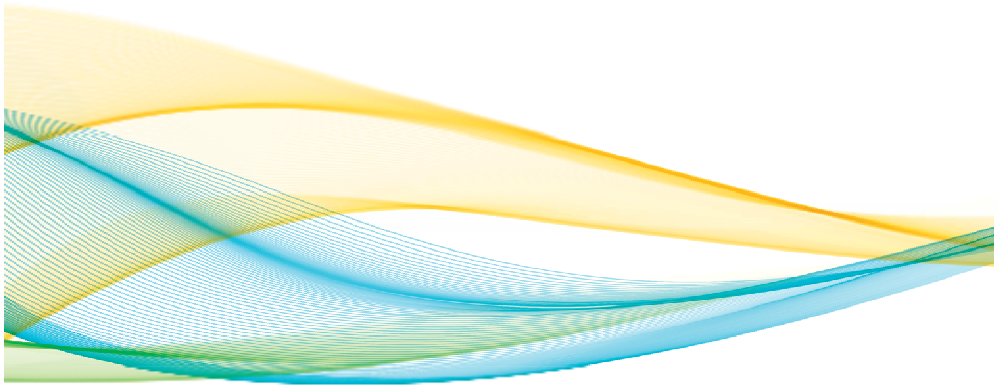
Proposed Budget

- The budget for each individual counties were based on population of county, which generally aligns with number of consumers served.
- In their EP programs, LA county will serve approximately 500 consumers per year, 82 per year in Orange county*, 260 per year in San Diego county, and 40 per year in Solano county.
- These numbers do not include all of the family and community members that will also utilize services via these EP programs.

COUNTY	FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	Total INN Funding Requested
Los Angeles	$565,482	$963,740	$876,102	$864,416	$843,054	$432,233	**$4,545,027**
Orange	$249,912	$499,824	$499,824	$499,824	$499,824	$249,912	**$2,499,120**
San Diego	$157,576	$227,148	$219,927	$216,285	$209,626	$96,828	**$1,127,389**
Solano	$42,340	$81,330	$86,037	$85,554	$84,670	$34,280	**$414,211**
							$ 8,585,747

*Orange county serves only FEP while other programs serve both FEP and CHRs.

Questions?



WELLNESS • RECOVERY • RESILIENCE

Proposed Motions (4):

The MHSOAC approves each of the following County's Innovation plans, as follows:

Name	Amount	Project Length
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

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Statewide Early Psychosis Learning Health Care Network

BACKGROUND The Prevention and Early Intervention component of the Mental Health Services Act (MHSA), coupled with a legislative focus on early psychosis (AB 1315, SB 1004), has served as a catalyst for the delivery of early psychosis (EP) services across California. Currently 24 counties have established EP services using state or federal dollars. Los Angeles, San Diego, Orange, and Solano Counties, in collaboration with the UC Davis Behavioral Health Center of Excellence, is seeking approval to use Innovation Funds to develop the infrastructure for a sustainable learning health care network for EP programs. Further, the proposed Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to clarify the effect of these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, will bring consumer-level data across a variety of recovery-oriented measures to clinician's fingertips and empower consumers to use their own data in care decisions. This project will also allow programs to learn from each other through a training and technical assistance collaborative 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.

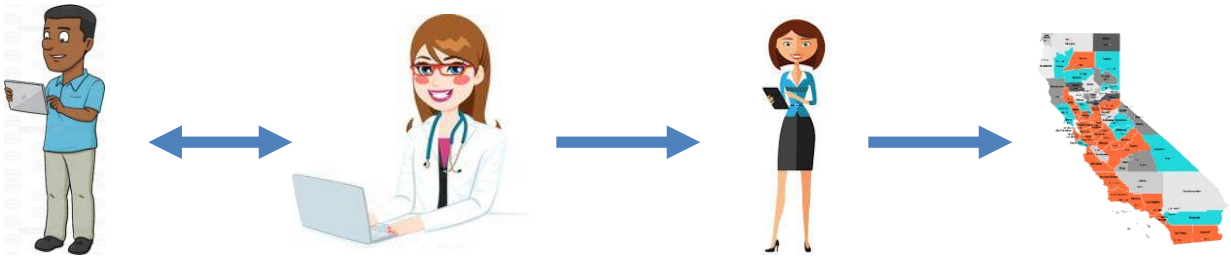
PRIMARY PURPOSE Increase the quality of mental health services, including measurable outcomes.

INNOVATION Project will make a change to an existing practice in the field of mental health that will increase the quality of services, including measurable outcomes. This creates a unified network of CA early psychosis programs to standardize practice and support knowledge-sharing, harmonizes EP evaluation across core outcomes to enable large scale evaluation and program development, and achieves measurement-based care via EP-focused technology platform, enabling participation for consumers and families across 13 languages. To date, no state in the United States uses this approach to harmonize data collection for EP programs and enhance EP care, illustrating the clear innovation of this project.

PROJECT LENGTH 5 years

PROJECT BUDGET $8,585,747

PROJECT OVERVIEW: In the first year, we will engage with stakeholders to review potential outcomes domains and measures, and then select a core set of outcomes to collect across all counties. Outcome measures will be loaded onto tablet for consumers and family-level data collection within EP clinics across years 2-4 with participation by approximately 2650 consumers. This data will be analyzed in the "Program level" analysis described below. Stakeholders will provide feedback on all components of the project through the "Qualitative data" component, while costs will be modeled as part of the "County level" data component.



CONSUMER LEVEL	PROVIDER LEVEL	CLINIC LEVEL	STATE LEVEL
Consumer (and family) enters data on relevant questionnaires or survey tools into app-based platform at baseline and then regular follow up	Clinician and/or MD can visualize responses on web-based portal for the individual over the course of treatment and share that data with the consumer during session.	Program management can visualize summary of responses on portal for: - All consumers in clinic - In relation to other programs in CA	Administrator level allows access to de-identified data across all clinics on the app for county- or state-level data analysis

PROJECT EVALUATION 1) Qualitative Data: Focus groups, stakeholder meetings & qualitative interviews with consumers, families & providers from EP and CG programs to inform outcome selection, review evaluation findings, and assess implementation and satisfaction. **2) Program Level Data:** Collect detailed outcomes (symptoms, functioning, satisfaction, etc.) measures in EP programs and evaluate impact of treatment within and between counties. **3) County Level Data:** Obtain de-identified data on program utilization, ED and hospital utilization and associated costs for early psychosis and comparator group (CG) programs (programs serving a comparable population in the same county with standard outpatient mental health services).

Response to Comments from MHSOAC Presentation 11-14-18

We deeply appreciate the feedback from the Commissioners and stakeholders in the audience. We would like to take this opportunity to respond to any remaining questions that were asked during the meeting on 11/14/18.

1. Community Involvement in planning

During the community questions segment, multiple stakeholder representatives enquired about stakeholder involvement – and involvement of their specific agencies – during project development.

We fully acknowledge that, to ensure any project meets the needs of the community, it is essential to solicit feedback from a multitude of channels.

Following the advice of the MHSOAC on 8/21/2018, project leadership contacted REMHDCO and MHAC for input on the project to determine if the project is addressing a current unmet need in a feasible and appropriate manner, in addition to any other comments/ recommendations. Zima Creason, the MHAC CEO, provided valued contribution to the proposal, and has offered support in ensuring the needs of stakeholders are represented during project implementation. Felix Bedolla from Napa County reached out to Stacie Hiramoto of REMHDCO on 8/21/2018 with a draft of the proposal for input but we never received a response. We would absolutely welcome any additional ongoing feedback from other stakeholder groups to ensure that needs are met in a feasible, sustainable manner, and will be reaching out again to the stakeholder advocacy groups in due course.

At the individual county level, LA County's stakeholder process involved LACDMH reviewing this project on January 17, 2018, April 18, 2018 and June 20, 2018 with the System Leadership Team (SLT). SLT members are comprised of consumers, family members and community members from the eight Service Areas Advisory Committees covering Los Angeles County. SLT members have also included organization representatives from city and county governments including the Department of Mental Health, educational organizations and mental health providers. Stakeholder priorities have reflected that of our Board of Supervisors, in that they support a broad array of services that begin with prevention for vulnerable populations. In 2017 stakeholders were very supportive of optimal services for Individuals with first episode psychosis. In 2018, stakeholders continued to express support for a cross-county learning opportunity that would result in robust and common outcome data collection and reporting, particularly in light of SB 1004. LACDMH also reviewed the EP LHCN project with the LAC Mental Health Commission on June 28, 2018. The Mental Health Commission also includes members who are consumers and family members of consumers from the five Board of Supervisor Districts.

Orange County's stakeholder process involved the Orange County MHSA office holding Community Engagement Meetings, workgroups, and community planning meetings specifically for providers and community members. These meetings revealed an interest in serving transitional age youth (TAY), as well as increasing services for this target population. OC Community members, providers and stakeholders have also repeatedly expressed an interest in increased reporting of outcomes during MHSA Steering Committee and local Mental Health Board meetings. Additionally, a consumer of the counties early psychosis clinic services was due to attend the 11/14/2018 presentation and speak in support of the project, but did not attend because there was not quorum.

San Diego County's stakeholder process involved conducting annual Community Engagement Forums as part of MHSA Community Program Planning. These annual forums are conducted throughout the San Diego county region and have included 1,950 stakeholders (including consumers, peers, family members and services providers) at 38 public meetings over the past three years. During these meetings, stakeholders have expressed a need for earlier assessment and the development and expansion of preventative education and intervention programs. Additional stakeholder comments expressed a need for a centralized, integrated, and accessible database to facilitate communication and coordination, and comments suggesting the use of technologies for education, outreach, and service provision.

Solano County has engaged in several comprehensive community stakeholder planning processes including the development of the current MHSA Three-Year Integrated Plan 2017/20, Annual Update FY2017/18, community planning related to the development of the Solano County Suicide Prevention Strategic Plan, and community stakeholder meetings for the MHSA Reversion Plan. For all community stakeholder meetings and the MHSA Steering Committee representation included: 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. Solano County has several strong partners representing the consumer and family member voice that consistently participate in community planning meetings. Solano county got feedback from stakeholders on the EP LHCN project specifically; stakeholders were generally in support as they feel this project will have a positive impact on their community and residents given recent data demonstrating that Solano County has a higher proportion of individuals with psychotic disorders in the population served than other MHPs statewide.

Regarding the technology which has been piloted at Sacramento Counties EDAPT clinic, consumer feedback has been solicited and found to be been broadly positive. This is evidenced by the letter written by Bonita Hotz and presented by Dr. Niendam as part of the MHSOAC presentation.

Underrepresented racial/ethnic minorities and members of the LGBTQ community were consulted as part of process outlined above. To solicit further feedback, REMHDCO will be contacted again for further input, and we have reached out to Poshi Walker at NorCal MHA for greater feedback from LGBTQ advocates. At this point, we would like to take this opportunity to apologize for not attempting to engage with this particular group; at the time we incorrectly understood them to be part of the MHAC who we did contact. Assuming their interest, we are looking forward to engaging with this organization in the future.

Going forwards, during the first two years of the project, significant resources have been allocated to ensuring that the needs of all stakeholders are fully represented. This process includes qualitative interviews and focus groups with consumers and family members to inform outcome measure selection, the development of the tablet interface, and to help identify barriers and facilitators to successful implementation. To guide project oversight, a steering committee will be established that will include consumer and family representation.

2. Concerns regarding project innovation

During the community questions segment, stakeholders asked if this project is "really innovative," noting that evaluations are already required for use of PEI dollars.

We apologize if this was not made clear in the materials presented; while the data that is collected can be used as the basis of a program evaluation, this is not an evaluation in and of

itself. Instead, we are proposing to transform how data is currently collected and used in these services.

At a consumer level, this means giving those receiving care a means to report their needs and experiences across a broad array of domains over time. This will be integrated with existing data in real time, and made available to consumers and clinicians in a clinically meaningful manner. This information can then be used to support shared decision making, ongoing treatment, and care planning within the consultation. At a program level, services can compare how they are performing against the state average to help identify areas for improvement, and then determine if any changes made are resulting in outcome improvements. Rather than just determining if the services in and of themselves are effective, the learning healthcare network should lead to significant improvements in service delivery as well as consumer outcomes.

3. Importance of shared decision making and consumer control of recovery

Both stakeholders and commissioners asked how this project will be useful to consumers in addressing recovery goals and if the process involves shared decision making, referring specifically to Dr. Pat Deegan's common ground philosophy.

The project has been designed to support shared decision making, and to focus on outcomes that are meaningful to all stakeholders (consumers, family members, clinicians, policy makers, and county staff). To ensure we successfully achieve this, in the first year of the project, we will host a series of focus groups all stakeholders that will inform outcome selection, ensuring coverage of domains considered most meaningful in the recovery process. For example, if the consumers' recovery goal is to complete a college education, the tablet can be used to track related areas of needs and strengths (for example: functioning, cognition, negative symptoms), identify where additional support may be required, and track the impact of that support over time.

Further, the project will involve evaluation of clinicians' use of data in care planning and provide specific training on how to engage consumers around their data to enhance treatment. Training will provide support around interpreting data from the system, engaging in shared decision making with consumers during treatment planning, and using data to track outcomes over time.

4. Peer specialist involvement

Commissioners asked how peers would be involved in this project and if peers would be available to support consumers' use of the tablets.

We recognize that peer specialists play a very important role in the delivery of high quality early psychosis care. The involvement of peer specialists will vary from county-to-county, depending upon the resources and availability within program involved. In Orange County, they plan to use some of the funds from this proposal to hire a peer specialist to manage the administration and oversight of the LHCN project. In Los Angeles County, their budget for the LHCN includes funds for one part-time community worker or peer specialist with lived experience of being diagnosed with a mental illness or having a family member diagnosed with a mental illness and has at least two years' experience with using electronic tablets and mobile application technology. This community worker or peer specialist will be dedicated to coordinating and assisting consumers to enter their data using the dedicated tablets. In San Diego, the Kickstart program employs four full-time peer support specialists who will be available to provide support to consumers who need the additional assistance when entering the data on the tablets. In Solano County, the EP program has a "Family/Peer Advocate" position. This provider works closely with the consumers

and family members with psychoeducation, educational and employment services and general support. This staff person can provide assistance with completing the self-reporting measures on the tablets as needed. Additionally, the program has an Intake Coordinator, who will be funded by the EP LHCN and she too can be available to provide support as needed.

The tablet user interface and outcome selection has been designed to enable most consumers to complete the tablet without additional support. However, in some cases additional support may be necessary, which will be provided by the peer specialists. In addition, in some programs, the peer specialists will be involved in providing additional support to help consumers achieve their recovery goals, as identified through using the data collected in the consultation.

5. Project Planning Process

Commissioners and stakeholders enquired about the timeline of the project, noting that development of this project began in 2015, and why UCD was leading the project.

First we would like to clarify that the previous 2015-2018 MHSOAC grant and the current proposal represent 2 distinct projects. The first grant focused on determining how we could implement statewide evaluation of early psychosis programs. It involved identifying and surveying the current early psychosis programs to better understand what programs existed, identify what services they offered, and what data they were collecting, to determine the feasibility of a county-wide program evaluation. This information was used to propose a prospective statewide evaluation of EP programs. Following the conclusion of that project, the MHSOAC proposed that UC Davis engage with the counties who had been involved in the 2015-2018 project to determine what would best fit their needs going forwards. These counties suggested that a learning healthcare network that could reduce service isolation, be available for use within clinical service, and inform service structure in a sustainable way would be much more useful than a large scale statewide evaluation. The initial idea and proposal was developed collaboratively over time between staff at UC Davis, UCSF, the programs, and county staff, rather than in response to a specific RFA. Consequently, this is not a project that could have gone out for RFP.

With regards to the counties that have decided to participate in this collaboration, no counties were hand-picked by UC Davis. Instead, it was these counties that made it clear both between themselves and with the UC staff that had they had the early psychosis programming infrastructure, the resources, and consumer need to participate in such a collaboration. UC Davis and Solano, Napa, LA County and San Diego Counties were involved in the initial discussions. County-led discussions lead to a number of other sites expressing an interest in joining at a later phase, along with Orange County who expressed a willingness and capability to join in the current proposal.