



WELLNESS • RECOVERY • RESILIENCE



Commission Packet

Commission Meeting
January 24, 2019

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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



Mental Health Services
Oversight & Accountability Commission



WELLNESS • RECOVERY • RESILIENCE

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

****DATE CORRECTION****
Commission Meeting Agenda

January 24, 2019
9:00 AM – 5:00 PM

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Public Notice

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

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

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting Lester Robancho at (916) 445-8774 or by email at mhsoac@mhsoac.ca.gov.

Khatera Tamplen
Chair

AGENDA
January 24, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM Convene and Welcome

Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, A'Keiona Moore. Roll call will be taken.

9:05 AM Announcements

9:15 AM Consumer/Family Voice

Kristina Saffran will open the Commission meeting with a story of recovery and resilience.

9:40 AM Action

Approve November 14-15, 2018 and December 17, 2018 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the November 14-15, 2018 and December 17, 2018 meetings.

- Public Comment
- Vote

9:45 AM Action

2: San Benito County Innovation Plan

Presenters:

- Alan Yamamoto, L.C.S.W., Director, County Behavioral Health Services
- Don Bradley, San Benito County Sheriff Department
- Rebecca L. Smith, Veterans Justice Outreach Specialist
- Nancy M. Callahan, Ph.D., I.D.E.A. Consulting

The Commission will consider approval of \$2,264,566 to support the San Benito County Behavioral Health Diversion and Re-entry Court Innovation Plan.

- Public Comment
- Vote

10:25 AM Action

3: Calaveras County Innovation Plan

Presenters:

- Jessica Xiomara Garcia, Director Learning for Action
- Kristin Brinks, Director Calaveras Health and Human Services Agency

The Commission will consider approval of \$706,366 to support the Calaveras County Enhancing the Journey to Wellness Peer Specialist Program Innovation Plan.

- Public Comment
- Vote

11:05 AM Information

4: Overview of Governor's Proposed Budget for Fiscal Year 2019-20

Presenters:

- Teresa Calvert, Assistant Program Budget Manager, Department of Finance
- Anam Khan, Health & Human Services Unit, Department of Finance

The Commission will be presented with an overview of the Governor's proposed budget for fiscal year 2019-20 and its impact on the community mental health system.

- Public Comment

11:45 AM Information

5: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

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

- Public comment

12:15 PM General Public Comment

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

12:30 PM Lunch Break

1:30 PM

Action

6: City of San Francisco Innovation Plan

Presenters:

- Farahnaz Farahmand, Ph.D., Assistant Director, San Francisco Department of Public Health
- William Martinez, Ph.D., Assistant Professor of Psychiatry, Director of the Child and Adolescent Services Clinic
- Angelina Romano, MSW/PPS, School Social Worker and District Coordinator for SFUSD's RISE Program

The Commission will consider approval of \$1,500,000 to support the City of San Francisco's Fuerte School-Based Prevention Groups Innovation Plan.

- Public Comment
- Vote

2:10 PM

Action

7: Legislative and Budgetary Priorities

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Norma Pate, Deputy Director, MHSOAC
- Greg Cramer, Policy Consultant, Office of Senator Beall
- Samantha Samuelsen, Legislative Aide, Office of Assemblymember Carrillo

The Commission will consider legislative and budget priorities for the current legislative session. In addition, the Commission has been asked by the authors to consider taking a position on the following bills: Senate Bill 10 (Beall), Senate Bill 11 (Beall), Senate Bill 12 (Beall), and AB 46 (Carrillo).

- Public Comment
- Vote

2:50 PM

Action

8: Documentary Funding Authority

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Tom Chiodo, Executive Producer, Special Projects, WETA
- Lisa Paulsen, Consultant, WETA; Co-Founder, Stand Up To Cancer

The Commission will consider authorizing the Executive Director to enter into contract(s) not to exceed \$300,000 to support a documentary project on mental health.

- Public comment
- Vote

3:30 PM

Action

9: Innovation Incubator Implementation

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- David Smith, Consultant, X-SECTOR LAB

The Commission will be presented with and consider adoption of an implementation plan for the development of the Innovation Incubator.

- Public Comment
- Vote

4:10 PM

Action

10: Immigrant and Refugee Request for Proposal (RFP) Outline

Presenters:

- Norma Pate, Deputy Director, MHSOAC
- Tom Orrock, Chief, Commission Operations and Grants, MHSOAC
- Angela Brand, Contract Lead, Stakeholder Engagement, MHSOAC

The Commission will consider approval of an outline and authorize the release of the Immigrant and Refugee RFP.

- Public comment
- Vote

4:45 PM

General Public Comment

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

5:00 PM

Adjourn

AGENDA ITEM 1

Action

January 24, 2019 Commission Meeting

The Commission will consider approval of the minutes from the November 14-15, 2018 and December 17, 2018 meetings

Summary: The Commission will consider approval of the minutes from the November 14-15, 2018 and December 17, 2018 meetings. 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) November 14-15, 2018 Meeting Minutes; (2) December 17, 2018 Meeting Minutes.

Handouts: None.

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
November 14, 2018

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

Members Participating:

Khatera Aslami-Tamplen, Vice Chair
Reneeta Anthony
Lynne Ashbeck
Senator Jim Beall

Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

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

Itai Danovitch, M.D.
David Gordon
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

DAY 1: November 14, 2018

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 9:18 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll; a quorum was not achieved.

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Announcements

Vice Chair Aslami-Tamplen reviewed the meeting protocols. She stated action items will be voted on at the next Commission meeting due to the lack of a quorum at today's meeting.

In honor of Veterans' Day, Vice Chair Aslami-Tamplen acknowledged the men and women who have served and are serving this country. She thanked them for their service.

Vice Chair Aslami-Tamplen asked for a moment of silence for the lives lost, the families who have been affected, and the firefighters and first responders who are working nonstop on the fires in California.

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. Royal Chukwudumebi introduced herself.

Consumer/Family Voice

Vice Chair Aslami-Tamplen stated Commission meetings begin with an individual with lived experience sharing their story. She invited Katherine Switz to share her story of recovery and resilience.

Katherine Switz, Founder and CEO of The Stability Network and Executive Director of the Many Minds Collaborative, shared her story of successfully living with bipolar disorder with recurrent psychosis, suicidal depression, anxiety, and OCD. She provided an overview of her lived experience related to mental health challenges, the challenges faced, the most effective approaches in services, how her life has improved, and ongoing recovery. She asked the Commission to show role models of recovery and to help eliminate social prejudice.

Commissioner Comments

Commissioner Brown thanked Ms. Switz for sharing her story of hope and for the work she does. It is inspiring to hear stories that show there can be a light at the end of the darkness that many people experience.

Commissioner Mitchell stated stories like Ms. Switz's give her hope that wellness is possible. She asked if The Stability Network can teach consumers and family members that recovery takes work.

Commissioner Anthony stated, along with the work that recovery takes, she heard Ms. Switz say it also took insight, acceptance, and a desire to overcome her challenges.

Vice Chair Aslami-Tamplen stated the message of hope and recovery can never be lost. She stated it is not an easy journey; it takes personal responsibility to go on that journey. She agreed with Ms. Switz that the support system is critical and having role models and peers that provide hope. She stated the Commission will continue to collaborate and find ways to involve Ms. Switz's work and others in the communities who are making a difference.

ACTION

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

Commissioner Brown referred to first line after the bullets for Agenda Item 5 on page 11 of the September 27th meeting minutes and stated, although he and Commissioner Wooton recused

themselves from the discussion and decision-making policies of that agenda item, they did not leave the room. He stated it was determined through the legal advice that it was acceptable to remain in the room. He asked to strike the words, “and left the room pursuant to Commission policy,” on page 11 and strike the language stating that Commissioners Brown and Wooton “rejoined the Commissioners at the dais” at the bottom of page 12. Similarly, he asked to strike the words “and left the room pursuant to Commission policy,” along with the language stating that he “rejoined the Commissioners at the dais” at the bottom of page 18.

Public Comment

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth, corrected the spelling of #Out4MentalHealth.

Vice Chair Aslami-Tamplen tabled the vote on the September and October meeting minutes to the next Commission meeting due to the lack of a quorum.

ACTION

2: City of Berkeley Innovation Plan (Extension)

Presenter:

- Karen Klatt, M.Ed., MHSA Coordinator

Karen Klatt, M.Ed., MHSA Coordinator, provided an overview, with a slide presentation, of the update to the MHSA Innovations Trauma Informed Care Plan and proposed extension of the plan that the Commission approved in 2016. She provided hard copies of the up-to-date budget for the proposed extension.

Commissioner Questions and Discussion

Commissioner Anthony stated a Berkeley study reported that the single biggest risk factor in being expelled was being a preschooler. There is not enough mental health training for teachers involved with preschoolers.

Ms. Klatt stated one of the great things about the Head Start Program is that many Head Start teachers are parents. That is a wonderful thing to help both at the home of that family and in the classrooms.

Commissioner Bunch asked about the evaluator’s early findings.

Ms. Klatt stated the evaluation is available on the website. Some of the findings were related to a project in the schools called Response to Intervention, where students get referred. It is an intervention before disciplinary action. She stated the year before the implementation of this project in the schools, there were only 14 referrals, but, after this project began, there were 55. This meant that, instead of the teacher going straight to discipline, the teacher referred the student to a group of mental health counselors and others who sit on a board to help schools determine the best course of action for each student.

Ms. Klatt stated the mental health follow-up remained the same, but the teachers felt more knowledgeable about things that were going on in their classrooms and they got more proficient in handling that in appropriate ways. A lot of it was more on the educators as opposed to the children. She stated the county is trying to get good, rich, entry-level, baseline data in the evaluation that predated the implementation of the Head Start piece to hopefully answer the learning questions asked in the original proposal.

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Commissioner Madrigal-Weiss stated it is critical to continue to work with the schools and let them know that this is not just one more thing but is part of what they are doing. That language and understanding must be facilitated for them. She asked if there was an attempt to help schools understand that this is part of what schools are already doing, whether it is part of Multi-Tiered Systems of Support (MTSS) or Positive Behavior Intervention Support. She asked if the project proponents used the language that schools understand because Trauma Informed Care Plan practices are the lens. She implored the city of Berkeley to have that conversation with the schools again. She stated the trauma does not go away after children age out of the Head Start Program.

Commissioner Madrigal-Weiss asked, as project proponents approached teachers and spoke to their triggers, if there was a plan to support educators' mental health thereafter. She asked if there was a plan in place to go further and talk about teachers' own wellness and services that are available.

Ms. Klatt stated she could get more information from the program manager from 20-20 Vision, who engaged with the schools about why the project was unable to go forward, if it would help the Commission make their decision. She stated she thought it was just the inability to release teachers for the mandated trainings that did not allow them to continue the program. She stated working with schools is a high priority. She stated the peer learning circles were for ongoing support.

Ms. Klatt stated the program is not written to say that it will connect teachers to resources, but she would imagine that resources would be made available for teachers. She stated she could follow up on that if it would be helpful to Commissioners.

Royal Chukwudumebi asked if the program works with elementary children. She stated that it is a huge segment of the population that needs help. Most of the time, when they act out, they need help because of something that is going on at home. She stated the time to start talking to children is when they are three to five years old instead of waiting until they are elementary school age.

Ms. Klatt stated elementary school children were included in the original program but project proponents will not continue working with that population. She stated this is a start of a trauma-informed care system in the city of Berkeley. It has to start somewhere and it will ebb and flow with the schools. There have been many initiatives and mental health partners with the schools. Sometimes it is prioritized and sometimes it is not. She stated it is a continuing conversation about how to get there. It is a priority with the city of Berkeley that all students are supported.

Commissioner Brown stated, although he was sympathetic to the staffing issues that are being experienced, the proposal is deficient when it comes to the evaluation process. It was troubling that, having experienced problems and issues, there was not more of a roadmap on where the project proponents intend to go. He suggested it would have been better to consult with an evaluator or an evaluation group to determine the objectives and the roadmap to reach those objectives rather than waiting until an evaluator was hired to make a roadmap on how to evaluate.

Commissioner Brown asked why the University of California at Berkeley was not asked to help with evaluation and research in this project and if there was an attempt to work with local law enforcement agencies, fire departments, and hospitals that would be in a position to help inform teachers, Head Start parents, and other individuals who would be involved in this project with young people who have experienced a recent traumatic event. He suggested presenting a reworked and retooled project at a future Commission meeting.

Ms. Klatt stated the city is seeking approval on the extension of this project prior to starting the bid process for an evaluator. She stated they had not considered creating a pre-evaluation plan. Regarding the question on law enforcement, the city has a program called Mental Health First Aid for anyone in the community and law enforcement goes through Crisis Intervention Team (CIT) training. These are the ways that individuals can learn about programs and available resources. She stated she will take this back and work on better ways to educate the community.

Commissioner Brown stated his concern was more about having some way that the teacher or parent can get a heads up that there was a traumatic event that occurred that might not necessarily be on the radar. He stated he can send Ms. Klatt the name of a program that does just that. It goes through the schools and talks about marshalling resources. He suggested that, although the school has distanced itself from this project, the project proponents may want to try to retain the ability to get that notification if the work and evaluation is Head Start.

Commissioner Ashbeck stated the math does not add up. The project began in 2016, was approved for three years through 2018, received an extension through 2021, but spent only one year's worth of funding. She stated today's proposal is not another extension of the project but is a different project because preschoolers are different from Berkeley Unified School students. She asked for verification that the city is asking for additional funding through 2021 to begin a Head Start Program.

Ms. Klatt stated the proposed project seeks the same outcomes but for a different population.

Commissioner Beall agreed with other Commissioners' evaluation comments and emphasized their importance. He asked if Alameda County has a similar program to the one being proposed.

Ms. Klatt stated they have Head Start and are part of First 5, but she was unaware of a trauma-informed care project for this population.

Commissioner Beall asked why not. He stated he is looking for schools, mental health departments, and health institutions that do these kinds of partnerships. He asked if any exist in Ms. Klatt's area other than the project being proposed.

Ms. Klatt stated she could only speak for Alameda County programs she was aware of. They have different programs in the schools. She stated Alameda County and the city of Berkeley are two different mental health jurisdictions. She stated the city of Berkeley works in partnership with Alameda County at times through MHSA funds and others.

Commissioner Beall asked if the school districts work with Alameda County on mental health issues.

Ms. Klatt stated she would need to find that out and get back to the Commission.

Vice Chair Aslami-Tamplen stated Alameda County's children's system of care does focus on the zero to five population and there is a trauma-informed care initiative throughout the county and in collaboration with the city of Berkeley. The proposed innovation project offers some differences.

Public Comment

Poshi Walker stated there was not much information regarding the community planning process in the packet, so it was unclear whether LGBTQ community members were involved in the process. The speaker wanted to ensure there was training and competency regarding LGBTQ children and trauma, as there is a unique relationship between the two beginning as early as

two or three years old, including an increased risk for sexual assault. The speaker requested that Commissioners ask for a response to these concerns.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, agreed with Commissioner Brown's comments. The speaker requested more detail about who was involved in the community planning process and evaluation including client stakeholders, and on the budget. The speaker emphasized the importance of a meaningful community planning process and evaluation, which includes the client voice.

Ms. Klatt stated the project proponents hold community planning meetings and have an advisory committee with a diverse group of stakeholders, but there is always room at the table for more voices. She stated the evaluation goes through the MHSA advisory committee.

Vice Chair Aslami-Tamplen stated, since there was no quorum, there would be no vote today. Staff will reach out to the project proponents regarding future Commission meetings.

INFORMATION

3: Programs, Providers, and Services Tool

Presenters:

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

Brian Sala, Ph.D., MHSOAC Deputy Director, gave a brief overview of the background and objectives of the project. He turned the presentation over to the project co-leads.

Rachel Heffley, Associate Governmental Program Analyst, provided an overview, with a slide presentation, of the goal and components of the Programs, Providers, and Services Transparency Tool. She used counties called out by Commissioners to demonstrate the MHSA Transparency Dashboard.

Brandon McMillen, Associate Governmental Program Analyst, continued the slide presentation by reviewing and demonstrating the Fiscal Reporting Tool, Program Discovery Page, and Program Profile for counties called out by Commissioners.

Executive Director Ewing stated the line graph on the Fiscal Reporting Tool shows the surplus of funds above and beyond the annualized county revenue.

Ms. Heffley continued the slide presentation and discussed the Full-Service Partnership (FSP) Dashboard containing the high-level statistical data of each county's FSP programs. She stated the FSP Dashboard combines client-level data and outcomes.

Commissioner Questions and Discussion

Commissioner Mitchell asked if the line graph on the Fiscal Reporting Tool includes real-time data from the Department of Health Care Services (DHCS).

Executive Director Ewing stated the DHCS data is inputted by staff.

Mr. McMillen stated counties send their Revenue and Expenditure Reports to the DHCS and the Commission. Staff extracts that data and puts it into a database. He noted that almost all counties have been accounted for. He stated there was approximately \$3 billion in total reserves for MHSA funding at the county level at the end of fiscal year 2016-17.

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Executive Director Ewing stated outcome information will be built in over time. The reporting tool only reflects what the counties have reported. The Programs, Providers, and Services Transparency Tool is a great start. He asked for feedback on features that could be added to make it even more useful for the public to better understand how funds are being spent.

Commissioner Bunch stated this tool is great because counties can use it to see what is already being done in other counties in order to avoid replication. She asked how counties were made aware of what was being done in other counties before the creation of this tool.

Executive Director Ewing stated counties learned of the work being done in other counties through their annual policy meetings and word of mouth.

Commissioner Mitchell stated the work of the Commission has been amazing so far. She asked how the general public can manipulate the Programs, Providers, and Services Transparency Tool.

Mr. McMillen stated users can input any number of search terms. Users can also search for programs in a specific county.

Ms. Heffley stated counties report at the program level, not at the provider level. If a family member is searching for a particular provider for services, this tool is limited.

Royal Chukwudumebi stated the system of mental health care in California is different from other states in that it is more centralized. She stated she liked the Programs, Providers, and Services Transparency Tool, especially the Program Comparison tool that will help not only members of the public but also social workers, peer support specialists, medical personnel, and law enforcement to coordinate innovations and programs.

Royal Chukwudumebi stated the reason individuals often do not get the mental health services they need is not necessarily because they do not want them. They give up on the mental health system because they feel that the mental health system gives up on them. She suggested training social workers, peer support specialists, medical personnel, law enforcement, and others on this tool that lists all the mental health support systems in each county so they will be able to determine which programs to access to ensure that they send individuals to the best mental health programs that will benefit each individual. This can be a great tool to help many people in many different ways.

Commissioner Anthony asked about community or county involvement up to this point.

Mr. McMillen stated the staff has presented to several commissions and stakeholder groups. The data will be sent to the counties to prove that the information displayed is the information they intended to display. The feedback received has been incorporated to ensure that the tool will provide data that is of the most value. He stated it is an ongoing process.

Commissioner Anthony asked if that information could be published on the website.

Dr. Sala stated this has not yet been published on the website. It is planned to be published next year.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), congratulated and commended the Commission on this tool. It will be helpful to the public. The speaker stated it will raise many more questions than it answers but it is a fabulous starting place. The speaker encouraged the Commission to include demographic information about race/ethnicity and LGBTQ. The speaker stated the hope that the Commission will work toward disaggregated demographics through legislation or negotiations with the DHCS.

Andrea Crook stated the tool is amazing. NorCal MHA has been using the Fiscal Transparency Tool and it has been a valuable tool in support of advocacy efforts. The speaker stated one of the things NorCal MHA has learned from it, when looking deeply into the lack of meaningful community planning processes throughout the state, is that the majority of counties throughout the state are spending zero dollars on the community planning process where they are required to spend up to five percent of their annual revenues. Counties cannot have a meaningful community planning process without continually investing in it.

Andrea Crook stated NorCal MHA gave feedback to staff to include regulatory language to help individuals across the state with their local advocacy efforts. The speaker stated the recommendation does not appear to be included in the tool. Including that language would be helpful.

Andrea Crook stated it would be helpful to see the amount of funding being invested for the community planning process per county from the Revenue and Expenditure Reports.

Dave Nufer, California Depression and Bipolar Support Alliance (DBSA), stated the DBSA was delighted this tool is being developed. The speaker stated one of the DBSA's emerging objectives is to become more integrated into larger mental health provider networks. It is daunting and difficult to get information on which of the 5,000 California mental health programs will be helpful to its members. This will be a fabulous tool for DBSA members.

INFORMATION

4: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Programs, Providers, and Services Transparency Tool

Staff did a project on fiscal reversion a couple of years ago and the Programs, Providers, and Services Transparency Tool is an evolution of that work. Staff translated the Commission's identified priorities, values, and recommendations into the Fiscal Transparency Tool, which created questions on how funding is being spent and what outcomes are being realized. He stated there are a number of constraints, mostly around data consistency and cooperation with other state agencies in terms of accessing the data. He assured that staff is moving forward in a thoughtful way to be accountable and to provide the information the Legislature, Commission, and members of the public need.

Multi-County Collaboratives

There are seven Innovation plans in the queue after today's presentation. Staff has processed many Innovation requests in the last few months and has been encouraging collaborations. The Commission will hear a multi-county Innovation project presentation on early psychosis later today and staff has been working to facilitate multi-county collaboratives around school mental health, the Headspace projects, and criminal justice diversion. Multi-county collaboratives will help staff to address challenges in processing Innovation approvals, to take Innovations to scale, and to change state and federal rules in order to reform the mental health system in California. He stated there have also been discussions on reducing disparities and on better integrative care between addiction and mental health needs.

Executive Director Ewing stated the need for a county leader for each of the multi-county collaboratives. Providing technical assistance and facilitating that conversation is part of the Commission's four-prong strategy to enhance strategic investments of Innovation dollars, provide counties with greater technical assistance to support their success, strengthen the research and evaluation, and disseminate the lessons learned so Innovations are transformative in not just how counties operate and function, but how the state supports them.

Executive Director Ewing stated the agendas have been driven by the high workload for approving county Innovation plans. He stated the hope that, although the Commission has been meeting ten times per year over the past three years, the number of Innovation plans will go down through more multi-county collaboratives and that in turn will require the Commission to meet less often.

Staff Meetings and Conferences

Executive Director Ewing stated staff was asked at the last Commission meeting to make it easier to understand the conversations, meetings, and conferences staff has been participating in. He provided a summary of this month's activities:

- Staff recently met with the California Department of Human Resources (CalHR) to discuss the work on workplace mental health. They are enthusiastic about partnering with the Commission on that. CalHR represents over 200,000 state employees. Staff is thrilled to engage CalHR to think about how to create mental health in the workplace for state employees.
- The Client and Family Leadership Committee recently met.
- The Cultural and Linguistic Competence Committee will soon meet.
- Staff presented the Programs, Providers, and Services Transparency Tool to the Council on Criminal Justice and Behavioral Health. They were interested in criminal justice and diversion kinds of programs.
- Executive Director Ewing attended the West Coast Community College District meeting at Harris Ranch in Coalinga. He stated they are interested in mental health in community colleges and in creative approaches to solving workforce needs in the broad health care space specific to the mental health space.
- Staff visited the Golden Gate Bridge to see the progress on the suicide deterrent nets being installed. It is an approximately \$190 million project, of which the Legislature donated \$7 million through the Commission in support of the project. That work will progress through the upcoming year. Staff plans to arrange another opportunity to see the progress as it gets closer to completion.
- Staff is presenting at the Breaking Barriers 2018 Interagency Symposium today in Sacramento on integrative care for youth.
- Executive Director Ewing and Commissioner Brown will present at a Words to Deeds event this Friday in Los Angeles.
- Staff will soon present the Programs, Providers, and Services Transparency Tool to the Primary Care Association.
- Staff will present at the Behavioral Health Directors Association Policy Conference in San Francisco in mid-December. Commissioners who are interested in attending can email staff.

- Executive Director Ewing will present before the Organization for Economic Cooperation and Development on the work being done on prevention for children at the end of November in South Korea.

Commissioner Questions and Discussion

Commissioner Ashbeck stated she has been asking how anyone even knows what is out there. She stated the Programs, Providers, and Services Transparency Tool is awesome. She stated all eight children's hospitals in California convened in October to discuss behavioral health. Thirty-five individuals attended. Cross-sector opportunities will be interesting going forward. She thanked the Commission for encouraging that work.

Executive Director Ewing stated part of the conversation through the strategic planning discussion has been the Commission's jurisdiction over the MHSA dollars, public mental health programs, and the state of California to respond to individuals with mental health needs. He stated his perspective, which comes out of his work with the Little Hoover Commission that framed a lot of this discussion on the goal of the MSHA, is to ensure that everyone who needs care gets care and that smooth pathways are created to access to care for individuals on the private sector, personal insurance side to get the support, coverage, and care needed through health plans.

Executive Director Ewing stated this will be included in tomorrow's meeting and is a point for discussion because there are tensions around this. He stated the goal is not just the MHSA programs; it is all of the public programs. It is not designed to help someone access care, it is designed to help individuals understand the system, and that means the entire mental health system must continually be pushed to reflect that, including the private sector side.

Commissioner Mitchell stated the Executive Director and staff do amazing work. She stated she is always touched by what everyone contributes to mental health wellness in California. She stated the term "transformative" has been resonating with her over the past few months. Listening to the speakers this morning brings it home, but there are still many people in the state who are unaware of what the Commission does and the opportunity to be transformative with Proposition 63.

Commissioner Mitchell asked if there is a possibility through legislation that the Commission can do a mental health campaign. There is Mental Health Awareness week every year that puts everyone in a mental health awareness public engagement mindset. She suggested a mental health campaign to educate communities with messages to bring mental health awareness twelve months out of the year. The way to educate the public regarding this issue is to keep it in the public mindset.

Executive Director Ewing stated there was a public communications campaign called Each Mind Matters. This was an initiative funded with Proposition 63 dollars where the counties allocated funds to the California Mental Health Services Authority (CalMHSA), which organized and led that program, but the funding ran out. There is interest in continuing to do that kind of work but the issue is how to pay for it. There is no specific allocation in the budget for that.

Executive Director Ewing stated that does not mean the Commission is not doing things that are related to putting this issue forward. He stated last year the Governor signed Senate Bill (SB) 1113, which authorized the Commission to work with the private sector to create a voluntary standard for mental health in the workplace. This will ideally become an opportunity to engage every major employer in California.

Executive Director Ewing stated the Commission has been invited to participate in a three-part documentary series on mental health with Ken Burns, a multimillion-dollar national initiative to

develop educational materials for schools around the country. With the chair's agreement, this will be put on the January agenda. The idea is to present these messages in a cost-effective way; however, the Commission's social media strategy needs to become more robust. The strategic communication initiatives need to be integrated into the Commission's strategic planning process. Executive Director Ewing stated he would be happy to ask the Legislature for resources to support a traditional campaign. The work that CalMHSA did was funded with county dollars, which is appropriate because it causes the communication to be oriented towards the communities at the county level.

Commissioner Mitchell stated people are insensitive to mental illness because they cannot see it. She stated the desire to educate the public about the pervasiveness of mental illness to create more awareness.

Commissioner Anthony thanked Executive Director Ewing for his direction and staff for what they have achieved. She emphasized the importance of not losing sight of the statewide need to coordinate relationships between agencies and between counties to prevent individuals from being left behind by technological advances. She stated the hope that departments will cultivate a robust relationship to carry out activities.

Executive Director Ewing stated staff is doing a number of things. They are working with UCLA to understand key metrics to determine barriers in the application process, and with the DHCS and the Department of Social Services at the state level to facilitate conversations about supporting opportunities at the county level regarding Medi-Cal and child welfare.

Commissioner Madrigal-Weiss thanked staff for their work and stated the hope that the Programs, Providers, and Services Transparency Tool will change practices across the state. She stated having counties look into that to determine what is innovative is important. There are campaigns for mental health awareness in certain counties, but they should be statewide. She stated it is unacceptable to have completely different practices in different counties. There should not be a different set of services or methods of treatment depending on location where there is funding available. It is not about money; it is about learning and practice, and the Programs, Providers, and Services Transparency Tool will help.

Executive Director Ewing stated the data, programs, and funding are intended to help the public and policymakers understand the situation. As the Commission works towards the outcome measures, the gaps will become clear. What is missing is technical assistance. While the Programs, Providers, and Services Transparency Tool will help Alameda and San Diego Counties learn about each other's practices, the infrastructure to help them move forward has not yet been built. The counties have mentioned that it would be helpful to establish a clearinghouse and technical assistance center. He questioned how the state can support the ability of the counties to learn together. There will always be variation but individuals should not be required to move locations in order to get their needs met.

Public Comment

Poshi Walker referred to 4(a), Presenters and Biographies, of the Commission Meeting Presentation Guidelines document, which was included in the meeting packet, where it requests no more than two to four presenters per Innovation project. It goes on to say that, if the county wishes to bring more presenters, support may be provided during the public comment period. The speaker stated stakeholders see that, while presenters are limited in time, they may bring several presenters who extend the presentation and may cause public comments to be limited. It is important to hear the voices of the community. The speaker suggested giving counties a separate five-minute comment time for their additional presenters.

Andrea Crook stated the multi-county partnerships are an area of concern. The Technology Suite Collaborative Innovation Project is an example of this, as they did not go through a meaningful stakeholder process. The speaker asked about the intent and requirements and how to ensure the community planning process is robust and meeting the needs of the community. Another concern is that Innovation pilots may not work. The speaker questioned the number of counties that express this as their primary need.

LUNCH BREAK

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

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

Tracy Lacey, LMFT, Senior Mental Health Services Manager, MHSA Coordinator, Solano County Department of Health and Social Services, stated this project is led by a team at the University of California, Davis (UC Davis) in collaboration with the University of California, San Francisco (UCSF), the University of California, San Diego (UCSD), and partnering counties. She provided an overview, with a slide presentation, of how early intervention is key for psychosis, the need for, and the county collaborative effort for the proposed project. She stated it is a statewide quality improvement project representing a collaboration between academic institutions, multiple counties, and the consumers and family members who will be served. She stated each of the four counties in the collaborative has gone through a comprehensive community stakeholder process.

Tara Niendam, Ph.D., Associate Professor in Psychiatry, UC Davis, and Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics), continued the slide presentation and discussed the innovative components and the goals of the proposed project. She summarized the project from the consumer/family member-, provider-, clinic-, and state-level perspectives. She stated she provided information about the security of the tablets and system in the project brief, which was included in the meeting packet.

Dr. Niendam stated this project has already been piloted in three counties and has received positive feedback. She read a letter of support from a family member whose daughter used this

technology in the Early Diagnosis and Prevention Treatment Clinic (EDAPT) in Sacramento County.

Mark Savill, Ph.D., Assistant Professional Researcher, UCSF, continued the slide presentation and discussed the evaluation of the proposed project. He stated the project is comprised of three distinct data components: county level, program level, and qualitative.

Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County Department of Mental Health, continued the slide presentation and discussed the impact the proposed project could have on the behavioral health system in California. She stated it is incumbent upon counties to come together to act jointly in the implementation of early psychosis programs to collect common outcome data that concerns the impact that these programs have on families, communities, and across the state, and to learn collectively and jointly.

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

Commissioner Questions and Discussion

Royal Chukwudumebi suggested helping the users of the application feel that they have greater control of their recovery from the peer support specialist side and from the provider side. She suggested that the providers know to come from a softer, recovery angle toward the consumer and not just use the consumers' information for data collection. This tool is a great thing for the community, but it can be a thin line to walk.

Dr. Niendam stated she liked Ms. Chukwudumebi's points. In terms of the data, one piece in developing this application is to help the consumer feel comfortable with the experience. Consumer feedback about the look and feel of the application is to try to make it friendly and comfortable rather than scientific or sterile. The questions are not all about how badly the person is feeling, but about where things are also going well and where the person feels empowered in their recovery.

Ms. Chukwudumebi suggested that the application be more like a wellness plan and that the questions asked be about the goals the user wants to accomplish and where they want to be in one year or five years. Making the application come from a recovery angle will help the provider help the individual while also collecting their data so there is good coming out of the proposed project.

Dr. Niendam stated one of the most important pieces being done in this project is supporting the clinical staff to use the data in a way that helps guide toward consumer-driven recovery and brings data into developing a recovery plan. That is one of the big pieces being worked on in the development of this project that will hopefully expand as part of the proposed project. She agreed that it is very important.

Ms. Chukwudumebi stated the application should be consumer-focused. Even though the project will use monetary resources, as the providers are using the data being collected, they should consider using non-monetary resources such as connecting with school counselors, wellness partners, social workers, and others.

Commissioner Ashbeck asked how UC Davis was included in the collaboration.

Ms. Lacey stated Solano County currently partners with UC Davis to provide the early psychosis program.

Dr. Niendam stated UC Davis uses MHSA and Community Mental Health Services Block Grant (MHBG) funds to fund the early psychosis program. It is provided by local community-based

organizations (CBOs). She stated the county also contracts with UC Davis for training and consulting.

Commissioner Ashbeck stated the process has been too slow. The work began in 2015 with an assessment and will conclude in 2024; yet, at the end of 2024, there will not be a statewide network. The outcome will be the lessons learned from the four-county network.

Commissioner Mitchell agreed and asked if there were other counties included in the proposed project.

Dr. Niendam stated Napa County is currently going through their stakeholder process and is planning to join the collaborative to make a total of five counties. The proposed project is the foundation for the Early Psychosis Intervention Network (EPINET) application that was put through to the National Institutes of Health (NIH) earlier this month, which includes two other counties and six universities.

Commissioner Ashbeck stated she is struggling with a nine- to ten-year rollout from the initial assessment in 2015 to the full execution in 2024 that will serve 1,400 consumers at approximately \$2,000 per consumer. She asked about the speed of the rollout and how to scale the proposed project in a way that will change the delivery of these programs across the state prior to 2024.

Dr. Niendam stated other counties have expressed interest in participating in the collaborative project. She stated UC Davis has been doing this work with technology in early psychosis programs for a couple of years. One of the challenges is that this is a culture shift. Many consumers are comfortable with technology and are excited to use it. She stated part of the work will be to understand how best to shift the culture of practice within the programs as well. This will take some learning and some development of training.

Dr. Niendam stated part of the work of the collaborative is to come together, agree on the outcomes, finish the application, pilot it, ensure that everyone is happy with it, and then roll it out with training so that it gets implemented effectively. Dr. Niendam agreed with the TAY representative's comment that it is important that providers do not give inappropriate feedback because they did not know how to use the data. This is shifting how care is provided; the collaborative needs to ensure that care is provided well. She stated the application includes time for evaluation of the implementation of the network as well as collection of long-term outcomes data.

Commissioner Ashbeck stated it is not unlike the physical health care world where people wear Fitbits and send the data to the doctor. The doctor then needs to make time to review that data. She agreed that it is about adjusting the culture of the provider as much as the consumer. She stated doing the right thing may take a long time but she continues to wrestle with it.

Dr. Innes-Gomberg stated the four counties presenting today and Napa County can be considered the first cohort. Other counties will likely join the collaborative, particularly as the Commission begins to work on SB 1004 and the priorities that make sense for the Commission.

Vice Chair Aslami-Tamplen stated, as the Commission moves forward with statewide priorities and encouraging collaboratives, she did not see how a peer specialist is involved at the consumer level helping the consumer enter the data.

Dr. Innes-Gomberg stated Los Angeles County has put in two peer support specialists or community workers to help clients enter that information and to help them learn how this information can be valuable to them. She stated there is a treatment component in Los Angeles

that is outside of the Innovation to implement the peer model. There are peer positions there, as well.

Vice Chair Aslami-Tamplen asked about the peer involvement with the other counties in the collaborative in developing the tool and in helping consumers enter the data. She asked if the counties had looked into Pat Deegan's Shared Decision-Making survey tool that is conducted in clinic settings.

Dr. Innes-Gomberg stated, when engaging stakeholders in the proposed project and in the Technology Suite Collaborative Innovation Project, one of the stakeholders shared that Pat Deegan's work is relevant to what the county was presenting. Dr. Innes-Gomberg stated the work of CommonGround and the Shared Decision-Making approach are similar to what the projects want to accomplish with this multi-county collaborative and the Technology Suite. She stated data provides additional information to help make a more informed decision about care.

Dr. Niendam stated peer specialists have been used in the implementation of prior projects and it has worked well. She stated UC Davis would be happy to see peers as a part of the implementation team at all the sites.

Ms. Lacey stated Solano County's MHS-funded program has a family advocate who is working in that program and could provide support. In general, Solano Behavioral Health is moving in that direction where the county is trying to insert funds for peer specialists in all programs.

Vice Chair Aslami-Tamplen stated the hope that peer involvement will be included with all counties that join the collaborative in the future.

Commissioner Brown stated his questions relate to the Commissioners' questions that came up from the Staff Analysis. He stated the Proposal Brief has been modified to what is in the Staff Analysis. He asked how the variances in county data will affect the evaluation and how it will be controlled.

Dr. Savill stated the counties are collecting the same data but there will be patient-level differences. The counties participating in the proposed project are very different from one another and will have very different considerations. He stated the need to develop a fuller analysis plan. He stated the assumption that multi-level modeling will be used and the differences among the counties will be controlled across sites using random effects including co-variance.

Commissioner Brown asked if a data set had been identified that each county is expected to provide data on or if data will be mined out of the existing data that the county collects.

Dr. Niendam stated there is a table in the Proposal Brief that outlines the county-level component. She stated one piece of that is bringing all the county data together to see how to harmonize across the data sets, such as ensuring that the Medi-Cal Utilization Data codes are similar, among other things.

Dr. Niendam stated there are two waves of analysis that UC Davis will be going through. One would be a retrospective analysis to see if there is data that can be harmonized and if there is data that must be excluded due to dissimilarity issues. The other would be a prospective analysis, which would include program-level data collection. Everything will be worked out in the first wave, which will concurrently move forward with the tablet data collection in the programs.

Commissioner Brown asked who will have access to the identified and deidentified data and how that data will be segregated by county. He stated the assumption that there will be a collective and an individual county dataset with comparisons.

Dr. Niendam stated UC Davis will be working with the county's data collectors to deidentify the county Medi-Cal data and to create unique identifiers so that any data that is sent to the evaluation team will already be deidentified at the county level. Things can then be linked by those identifiers and the analysis can be done based on the linked identifiers.

Dr. Niendam stated the tablet data collection system is built to remove the identifier at the clinician level so the clinician and clinic management can see the client's name. Once it gets to the highest level, the system automatically deidentifies the data. The identifiers are removed from the analysis that will come to the evaluation team.

Commissioner Mitchell asked if it is possible for the Commission to see a demonstration at a future Commission meeting. She asked the presenters to walk through the process of how the data would feed across the collaborating counties starting with a tablet being given to a client.

Dr. Niendam referred to Figure 1, MOBI mHealth App and Dashboard, on page 3 of the Proposal Brief, which shows images of how the data is displayed. She stated the consumer would come in, receive the tablet, and go through a series of questionnaires. The interface is simple and clear. The tablets are web-enabled with a secure end-to-end connection. Everything is encrypted as it goes to the cloud, which is where the software is held. The data is then put on a web-based provider-facing dashboard.

Commissioner Mitchell asked at what point the client would receive help during this process.

Dr. Niendam stated the way it is typically done is the client is asked if they would like help. If they would like help, a peer, clinician, family advocate, or whoever they feel comfortable with can help them. It is designed to make sense at the front end. The measures that will be put on the tablet have been chosen for this population. The reading level and the questions that are asked have been validated and standardized. The hope is that the clients will feel comfortable working with the tablet on their own but that the program would provide them with support if they wanted it. She stated clients typically ask for help with the tablet ten percent of the time.

Dr. Niendam stated the providers log into a secure web-facing portal, go through, find the client, and click on their name, which opens up a dashboard for that client. The responses are populated across tabs. The dashboard has been designed for the consumer, the clinician, and the family to look at together. It displays the client's answers to the questions in graph form so the client and family member can visually track progress and the clinician can discuss variations displayed on the graphs.

Commissioner Anthony asked counsel about the six-year agreement and how many other contracts the Commission has approved for this length of time.

Ms. Yeroshek stated the maximum is a five-year length for an Innovation project under the regulations.

Commissioner Anthony stated it is spread over six fiscal years.

Ms. Yeroshek stated the regulations use calendar years and thus this project is a five-year project. Under the regulations the start date begins when funds are spent not upon approval.

Public Comment

Andrea Crook stated the Welfare and Institutions Code Section 5892(a) states "in order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows: ..." and 5892(c) states "the allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section

5848. The total of these costs shall not exceed five percent of the total of annual revenues received for the fund.”

Andrea Crook stated the California Code of Regulations Section 3300(c)(1) states “the community program planning process shall, at a minimum, include involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the community program planning process.”

Andrea Crook stated the last paragraph on page 8 of the Staff Analysis for the proposed plan states “all county plans were shared with MHSOAC stakeholders ... and no letters of support or opposition were received.” The speaker stated this is a concern. It is important that these plans are being born from the community and that counties are being good stewards of the community’s money and are ensuring that county programs are meeting the community’s needs as defined by that community.

Stacie Hiramoto echoed the previous speaker’s concerns about the community planning process. The speaker referred to page 7 of the Staff Analysis for the proposed plan under Cultural Competency and Community Planning Process that states that feedback was given on the proposed project by the System Leadership Team. The speaker stated, if the System Leadership Team is primarily made up of county staff and county contractors, there is a danger of them not wanting to say negative things for fear of losing their funding or their jobs. If the System Leadership Team meetings are not widely noticed or open to the public, then it is not a good measure for stakeholder participation.

Stacie Hiramoto stated there is a difference between communities bringing forth ideas versus the county asking for their feedback on a program. The speaker emphasized that it is not wrong if done that way sometimes but, if it is primarily how these projects come to fruition, that is not being community-driven. The speaker spoke in general support of the proposed project because it seems to be trying to find out information about early psychosis programs, which is needed; however, the questions the speaker had about early psychosis programs have to do with whether people of color and people from the LGBTQ community are accessing and being served by these programs in the proportion that they are eligible for them. The speaker stated the impression given by the REMHDCO members is they are not, they are expensive, and they would rather spend the funding on prevention and early intervention (PEI) programs.

Poshi Walker stated the Mental Health America is not necessarily the Mental Health America mentioned in the reports included in the meeting packet or #Out4MentalHealth.

Poshi Walker stated the comments are not a commentary on the efficacy or desirability of this program or whether this is a good or helpful program. The speaker asked if the proposed project is really innovative, given that evaluation and standardization are not innovative concepts, but, in fact, evaluation is required as part of MHSA programming. In addition, the Staff Analysis states this is already on the national scene with the National Institute of Mental Health (NIMH). It is not innovative and is already being done. The speaker stated statewide collaboratives are not innovative as this is already being tried with the Technology Suite Collaborative Innovation Project. The proposed project fits more with PEI funding than it does with Innovation funding.

Poshi Walker agreed with the concern about the community planning process. The speaker stated concern that it was UC Davis that identified the counties rather than consumers and family members coming to their counties to identify a need and was particularly concerned with Orange County because it was already found with the Technology Suite Collaborative Innovation Project that major stakeholders in LGBTQ communities were not consulted about the Tech Suite project. There was no mention of who was contacted or how it was done. The only mention of any kind of stakeholder feedback is at the bottom of page 8 of the Staff Analysis that

states the project was shared on one day, which is neither a meaningful or robust community planning process nor a meaningful or robust stakeholder process.

Poshi Walker stated concern about the funding given to UC Davis to write a report where that report found a lack of standardization. UC Davis was then given money to identify counties to work on it which then were sole-sourced the funding to run the program. The speaker asked why there was not a competitive process at least for the running of the program.

Flor Yousefian Tehrani, Psy.D., Program Manager, Orange County Innovation Projects, shared that a stakeholder was looking forward to this meeting but was unable to attend. Dr. Tehrani stated this stakeholder wanted to share their experience as a recent graduate of the first-onset program of the Orange County Center for Resiliency, Education, and Wellness (OC CREW). The stakeholder wanted to share their positive experiences and how the proposed project could impact OC CREW and the participants within it. Dr. Tehrani asked if this stakeholder could be allowed to share their testimony at a future Commission meeting.

Dr. Tehrani responded to Vice Chair Aslami-Tamplen's comments about peer involvement and that Orange County was not represented. The speaker stated Orange County does want to have a Learning Health Care Network Project Manager specifically for this program. The county envisions that person being hired through CalMHSA through a participant agreement with CalMHSA.

Project Proponent Response

Vice Chair Aslami-Tamplen gave the project proponents an opportunity to address the concerns brought up by Commissioners and members of the public about the community engagement process.

Ms. Lacey stated there have been multiple community planning processes around the Three-Year Plan, Annual Updates, and the Suicide Prevention Communitywide Plan in Solano County. She stated community members expressed significant concern about young people who are at great risk of homelessness, serious mental illness, and not getting early intervention. That has been a piece that has resonated in every community planning process.

Ms. Lacey stated, when the proposed project was brought for public hearing, one of the things that several of the board members wanted to do was to expand this even further to have every middle and high school student screened and to see if the tablets could be used to do that. The speaker stated there has been a community stakeholder process in Solano and there is a lot of support for this project.

Ms. Lacey responded to the comments about not addressing some of the disparities, racial/ethnic groups, and the LGBTQ community. She stated all counties involved in the planning process for the proposed project asked to ensure that demographic data was included on the tablets to address those communities. All questionnaires will be made available in 13 languages. It is impressive that this tool will have outcome measures that will be translated in those languages. The proposed project has continued feedback from consumers and family members built in and has as the core outcomes inpatient utilization, crisis stabilization utilization, employment, and homelessness. The counties are looking at how to address these core issues and how to create measures around them.

Dr. Innes-Gomberg stated the Los Angeles System Leadership Team is open to the public and has all representation that is listed in the MHSA. Los Angeles County got to this place over a multi-year process where it realized the current early psychosis programming was inadequate. She stated the county's PEI administration staff did a thorough review of the different practices

out there for this particular condition, identified the peer model, and have been working with Dr. Niendam for at least a year, if not two.

Dr. Niendam stated there were questions about the prior contract UC Davis had and this project. She stated UC Davis had a smaller project to develop a method for evaluating all of the early psychosis programs across the state, which came from the Commission. She stated, through that work, UC Davis met with the different programs and identified them all. She stated that was a feat in and of itself – bringing everyone together and putting out a survey to the programs, which had a 97 percent response rate, to better understand what each program was doing in order to determine if a retrospective study was possible using the data the programs already had. She stated UC Davis realized that there was so much variability that it could not work. Consumers, family members, providers from the homeless community, and various other minority groups suggested a prospective evaluation done together.

Dr. Niendam stated she presented that idea to the Commission over a year ago and it was positively received. She stated everyone realized this was something the counties could do together. The counties represented today have put this together and have a great deal of support in their communities. Much has been learned by partnering. Dr. Niendam assured that the proposed project is not a UC Davis top-down process but is a partnership to build something that will work for clients and communities.

Vice Chair Aslami-Tamplen stated she and Chair Boyd will work with Executive Director Ewing to select a date to convene another meeting to vote on the multi-county collaborative and Berkeley's Innovation project as soon as possible. She thanked the counties for their presentations and their time.

Commissioners Bunch and Madrigal-Weiss rejoined the Commissioners at the dais.

INFORMATION

6: Legislative Priorities

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing stated this is the time of year where policymakers begin to explore options for new legislation. He discussed a number of items based on Commission conversation and history and asked if the Commission would like to play a leadership, sponsorship, or support role.

Executive Director Ewing stated the first is legislation around peer certification. The Commission took a support position on a bill a couple of years ago that did not move forward because of opposition from the DHCS. Last year, Commissioner Beall authored SB 906, a peer certification bill, which was vetoed. He stated Vice Chair Aslami-Tamplen raised the issue of the Commission playing a sponsorship or support role again around peer certification and the opportunity for the Commission to see if it can get a better handle on the concerns from the administration that led to that proposal being shelved twice.

Executive Director Ewing stated the second issue that was raised was language in the code that is derogatory, inaccurate, or anachronistic, such as referring to individuals as insane or mentally disordered. The intent is not to change the meaning of the law in terms of its impact on programs but would be a technical revisit of some of the terms used to create more positive mental-health-oriented language that is more appropriate today.

Executive Director Ewing stated Vice Chair Aslami-Tamplen recently led a conversation on this issue with the Client and Family Leadership Committee. Although the Committee was supportive, they also recognized that there will be tensions with how far the language in the statute around issues of recovery can be pushed. He gave the example of language that refers to individuals as patients versus clients, consumers, or survivors. There may be areas where there would be a concern in the mental health stakeholder community that a particular term is not appropriate, but there may be tremendous political resistance or opposition to changing terms for cultural or historic reasons. There may be terms that are clearly amenable to updating and other terms that are considered unsuitable for updating at this time.

Executive Director Ewing asked the Commission for their feedback on legislative priorities.

Commissioner Questions and Discussion

Commissioner Anthony stated she appreciated the need for a change in language referring to patient versus consumer. She stated her concern is regarding diagnoses that identify serious mental illnesses. The legislation specifies serious mental illness for a reason and the reason those illnesses and type of illnesses are different. She stated this is a worry because, when the funding was initially established, it had to do with the fact that there was no money specifically to target the associated needs like supporting needs for persons affected by serious mental illness. It is a concern whenever talking about words in medical circles that have to do with identifying an illness.

Executive Director Ewing stated the intent is to stay away from issues where a change in the wording would have a substantive change in programming and, instead, to focus on language such as where the term “insane” might have been used and replace it with “someone with a serious mental illness,” or where the term “schizophrenic” might be used and replace it with “a person with schizophrenia.”

Commissioner Anthony stated those examples would be acceptable.

Executive Director Ewing stated this would be a technical revisit of some of the language to create awareness around what is meant by recovery, and these are often temporal designations. It is where a person has an illness at a point in time but might recover as opposed to this historical labeling language. The intent is not to change any program or eligibility criteria; it is simply to update the language to reflect more current usages of these terms knowing that there will be tensions even in that space. Staff would then, through the work of the Committee, bring language to the Commission for review.

Commissioner Anthony asked which Committee will work on the language.

Vice Chair Aslami-Tamplen stated the Client and Family Leadership Committee will work on the language.

Executive Director Ewing stated some of that conversation is already happening. He stated he wanted to provide examples of options of areas where the Commission might want to take positions in generating legislation as opposed to responding to legislation already in progress.

Commissioner Mitchell asked if the change in language would only be for the MHSA or if it would include the Government Code.

Executive Director Ewing stated it is open to the Committee’s direction. He stated he did not anticipate the need for many changes in the MHSA because it is relatively new. He stated the Welfare and Institutions Code and the Penal Code of California use terms such as mentally disordered offenders and mentally disordered sex offenders, which is a difficult population to respond to. The goal would not be to take on every challenge in terms of language or go

through every code section. The idea is to identify areas where the code can and should be updated such as the term “insane,” which is found throughout the statutes in a variety of ways. The idea is to begin the conversation with the Legislature about how language matters and it is possible, without making technical changes to the law, to begin to refresh the language and make it much more responsive to how mental health needs are understood today.

Commissioner Brown stated the other thing that needs to be considered is that there is language that is ingrained in the legal system as well as in other codes and common language. For example, someone being found “not guilty by reason of insanity” is a commonly-accepted premise across state and even international law. He stated the need to realize that, although some of these terms may be archaic, they are not necessarily pejorative in their usage. The reality is there is a historical context to them that oftentimes has ingrained itself into the law. It will be a much more difficult fix than simply doing a word search and changing words in the code.

Executive Director Ewing stated what will be encountered is not known. The idea is to get started and find consensus among Commissioners for legislation that would shine a light on some of these opportunities where there is not a tremendous amount of political opposition. There is often a reason why the words in the codes are there.

Commissioner Brown stated there also have been words historically for hundreds of years that have been eliminated from the vernacular such as lunatic and imbecile. This is a complex issue.

Executive Director Ewing asked if Commissioners would like to continue to work on peer certification legislation since the Commission supported the last two pieces of legislation on peer certification. He asked if there are other issues that the Commissioners would like an opportunity to shape legislation on.

Vice Chair Aslami-Tamplen acknowledged and thanked Commissioner Beall for authoring the last peer specialist certification bill, SB 906, and for agreeing to author the next one. It would be a huge advantage for all of California for the Commission to be involved in that with the Senator. She stated 48 other states are at least in the process of a peer specialist certification. She spoke in favor of the Commission’s support of peer certification legislation.

Commissioner Bunch agreed with Vice Chair Aslami-Tamplen and spoke in favor of the Commission’s support of peer certification legislation.

Executive Director Ewing asked Commissioners if there were other topics they would like staff to research in anticipation of the continued conversation at the January Commission meeting.

Commissioner Ashbeck asked if there was legislation that could be done based on the topics of schools, criminal justice, or fiscal reversion that has been learned through the public policy work the Commission has already done.

Executive Director Ewing stated, in terms of the Schools and Mental Health Project, the timeline is to have a draft outline to the subcommittee around the end of the calendar year that will frame out possible opportunities. He stated, often prior to completion of the work, the Legislature will look at those types of draft discussions and say it sounds right and a coalition of supporters will line up to continue the work. He gave the example that, even though the Commission did not finish the Children’s Crisis Services Project work, approximately \$80 million was allocated to enhance access to crisis services for children.

Executive Director Ewing stated there have been discussions in terms of the Fiscal Reversion Project. There are at least two perspectives on this. He stated Assembly Bill (AB) 114 was the trailer bill legislation that allowed counties to keep the funds that otherwise should have reverted

on the condition that they had a plan by June 30, 2018 on how to spend the funds, and to spend the funds by June 30, 2020. There was also a line in the bill that stated, upon approval by the Commission for Innovation spending, the clock would reset.

Executive Director Ewing stated the challenge is that the legislation did not clarify which of those two statements would prevail. He noted that the clock will not reset on the PEI, Community Services and Supports (CSS), and the other funds that were subject to AB 114. He stated the question is if the clock will reset on the AB 114 Innovation funds with the Commission's approval. He stated Chief Counsel and Department of Finance's interpretation is that it does not, but in speaking with the staff who wrote the legislation, they recognize that they did not have a perspective one way or the other. He stated part of the pressure is that counties must spend the funds prior to June 30, 2020. He stated the County Behavioral Health Directors Association of California (CBHDA) asked at the end of the budget process last year to clarify that the clock would reset on the AB 114 funds. There are arguments for and against that. It was put on the Commission agenda earlier this year and the Commission chose not to take a position on the issue.

Royal Chukwudumebi stated everyone has a different perspective on peer certification, just like most people do not think that they know anyone who has gone to jail and most people who do not live in California have a different perspective on Californians. She suggested that a quicker way to pass peer certification legislation is to help the opposing organizations and legislators see an individual who is currently working as a peer support specialist even though the certification has not yet been approved. She stated everyone has a different perspective of what mental illness or serious mental illness looks like. Most people do not think they know anyone with a mental illness or think it is a very shameful thing. She stated the need to put someone who is in the process of recovery or who is successful in their recovery and someone who is a peer specialist helping others with their recovery in front of the individuals who previously opposed the legislation. This might stop them from saying no to the next piece of legislation on peer certification.

Vice Chair Aslami-Tamplen thanked Ms. Chukwudumebi for bringing that up and encouraged her to keep up her advocacy to empower peers. She agreed that peer specialists should be at the forefront speaking to legislators and organizations.

Vice Chair Aslami-Tamplen suggested legislation that prevents Not in My Backyard (NIMBYism) of mental health programs, particularly peer respites and substance abuse programs. She stated NIMBYism can stop programs from opening up and serving the communities in the most effective ways.

Executive Director Ewing stated some of the challenges faced in terms of data sharing are that there is a line in the statute that says that the Commission has the right to receive information but that often is not adequate. The Commission has struggled to get data use agreements with other state agencies because they put tremendous conditions on the data that make it impossible for the Commission to get the data.

Executive Director Ewing stated the Commission has sponsored legislation in the past on enhanced reporting requirements, including reporting out on at least estimates of how much mental health funding is going towards things such as reducing unemployment, serving veterans, or preventing suicide, but the legislation was vetoed. There also was a bill that would have allowed the Commission to visit facilities that are not open to the public without violating the Bagley-Keene Open Meeting Act rules. There was late opposition from the DHCS, which resulted in the Governor vetoing the bill. The Governor's office signaled that, if the Commission had a chance to pull the bill back and make minor amendments, the Governor would have been

receptive to signing it. The Commission was unable to do that because of the legislative recess and short timeline.

Commissioner Beall stated mental health legislation went through the Legislature almost unopposed last year. The problem was not the Legislature; if anything, they are impatient that not enough is being done. He stated the problem was with the DHCS. The DHCS has been without a mental health director since February and a replacement has not formally been appointed. The new Governor seems to be engaged and interested in mental health issues. He will be tasked with appointing key mental health individuals who are close to him. Appointing individuals who are advocates for mental health will go a long way. Commissioner Beall stated the hope that significant work will be done this upcoming year.

Commissioner Beall asked everyone to keep an open mind about upcoming bills and to try to think bigger than they have in the past to come up with good ideas.

Commissioner Beall stated a compromise was made as the peer certification bill went through the process this past year trying to gain DHCS support. The bill originally had certifications for subcategories of peers such as young people, LGBTQ, trauma survivors, substance abuse, consumer, family, and others. The DHCS thought peer subcategories would be too expensive. The bill was amended to one certification but the DHCS continued to oppose it.

Commissioner Beall suggested a broader mental health approach and taking a greater step in the role of the Commission in giving advice to the Legislature. He stated there are many legislators who would like to author legislation on mental health. There were 40 bills that had a relationship to mental health last year; they were all vetoed. The veto rate for mental health bills is approximately three times the veto rate of all other bills. He stated he is the chair of the committee that is currently analyzing this and will give an After-Action Report to his colleagues. He stated, if the DHCS has the same team as before, the next bill will encounter the same problem.

Commissioner Brown stated the Governor's veto message specified his reason for doing so was because he felt it was not inclusive enough and encouraged a change in that. He asked Commissioner Beall to comment on whether there were certain advocacy groups that were opposed to this because they thought it would restrict peers from being involved.

Commissioner Beall stated the Governor's office called him to discuss why the bill was vetoed but that was not mentioned.

Vice Chair Aslami-Tamplen stated the bill was not going to leave peers out who are currently working in the field. There was a grandfathering-in piece to the legislation. She suggested inviting the DHCS to explain their reasons for opposing the legislation at a Senate Subcommittee meeting or at a future Commission meeting. It is important to gain their support for future legislation.

Public Comment

Stacie Hiramoto strongly recommended convening a Legislative Committee this year. Last year, the Commission took a position on many bills. The speaker spoke in support of the Commission taking positions on bills but stated the process was not always organized and there was no time to analyze the bills. A subcommittee could help with organization and analysis while also allowing Commissioners and stakeholders an opportunity for greater discussion and to provide input in a meaningful way, particularly on legislation pertaining to the Commission budget.

Poshi Walker agreed with the previous speaker about convening a Legislative Committee to support the Commission. The speaker reminded the Commission that part of the role of the

stakeholder contractors is statewide policy work. The stakeholder contractors are already looking at legislation from the different perspectives that will help with the discussion. The speaker suggested hearing both pro and con positions from individuals who are invited to discuss legislation.

Poshi Walker agreed with Commissioner Ashbeck's idea about staying in lanes the Commission is already in. The speaker stated the Commission has yet to review #Out4MentalHealth's State of LGBTQ Communities Report. One of the recommendations has to do with sexual orientation, gender identity and expression (SOGIE) data collection. The speaker requested true oversight and accountability for all SOGIE data collection. There needs to be some teeth to ensure compliance. Nothing currently happens if data is not reported, so often it is not collected and reported.

Poshi Walker stated what was found in the research collected was that counties are collecting data, putting it together, and reporting it in many different ways. The speaker stated, even though there have been regulations, statewide agencies are collecting and reporting the data in different ways. The speaker requested funding for analysis at the statewide level to help all groups in demographic data categories. Currently, everything is siloed. The speaker stated it would help show the disparities if the counties reported the disaggregated data for each client and the state analyzed it.

Poshi Walker stated the need for awareness that federal SOGIE data collection is diminishing. Even data that has been collected is not being reported anymore. California SOGIE data has become even more important to the state and to the country as a whole and is important for addressing disparities for LGBTQ Californians.

Steve Leoni, consumer and advocate, discussed the changes of language in the codes. The speaker stated it may not fully work. What is bad code language for one person may not be bad for another, although they both want the same thing – dignity and respect. This needs to be taken into account. The speaker agreed that there is a history here, such as with the word "patient." The speaker stated a colleague once stated the relationship between clinicians and consumers was defined by the evolution of three words: doing something "to" people, doing something "for" people, and doing something "with" people. The speaker stated words like patient firmly stay in the column of doing things "to" people, which has a bad connotation for many individuals who experienced that in the past. The speaker stated the word patient was innocently used during the last Commission meeting and it gave them the shivers.

Steve Leoni stated there is a racial term that ends in "o" that he has learned not to use but it used to be a common academic and common-use term not usually meant pejoratively. The problem is the word comes with baggage, with stereotypes, and should no longer be used. That word and the word patient have that same cringeworthy feel. This work still has a great deal of relevance.

INFORMATION

7: Innovation Incubator Update

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing reviewed the Staff Summary, which was included in the meeting packet, of the background and work done to date on the Innovation Incubator. He stated three steps have been identified that will be important in terms of this broad work:

1. Developing an Innovation Roadmap
2. Building a Learning Community
3. Establishing an Innovation Incubator

Executive Director Ewing asked Commissioners for their input on the first two components.

Commissioner Questions and Discussion

Commissioner Mitchell asked how the Building a Learning Community component is being envisioned.

Executive Director Ewing stated staff has yet to have these conversations with the counties, but it will be more of a technical assistance center. California funded two Centers of Excellence in Behavioral Health – one at UCLA and the other at UC Davis. Those funds have now run out, but the idea was to create a place the counties could turn to for technical assistance and guidance on particular topics.

Executive Director Ewing stated today's proposal, which will require more research into how this has worked elsewhere, is the idea of joint state and county funding that would provide resources for issues the counties struggle with. He stated the Building a Learning Community component is envisioned as a Center of Excellence type of model, which will be nonprofit- or university-based. The biggest gap in the ability to drive transformational change is the ability to learn from each other and the ability to deploy the right kind of technical assistance around missed opportunities and shared lessons.

Commissioner Mitchell stated she liked the idea but wondered if all the necessary work for staff to create the three components has been considered. She asked about the implementation process.

Executive Director Ewing stated the question today is whether the Commission is interested in pursuing the proposal. If so, those conversations can begin to find answers, models can be considered, and the Legislature and the Department of Finance can be approached about funding. This is not a new challenge; it is an old challenge but it has not been addressed as effectively as possible in the mental health space.

Commissioner Ashbeck stated this is exactly what the Commission needs to do and the three components are appropriate. The piece that is implied in the Developing an Innovation Roadmap component is the aggregation of outcomes to see that the care is transformed. She stated knowing that a county did it is one thing; knowing that they did it and it failed is entirely different but equally as important.

Commissioner Ashbeck suggested broadening the "Schools and Mental Health" example in the Building a Learning Community component to a broader "Children and Mental Health" network. She stated there are effective models in transportation planning where metropolitan planning organizations offer technical assistance to small cities that cannot apply for federal dollars of any kind.

Commissioner Ashbeck suggested adding the notion of workforce in the Building a Learning Community component. She asked who will do the psychiatry, nursing, and peer work in the future. That is something that counties may not be able to do on their own.

Vice Chair Aslami-Tamplen suggested tracking the Commission's success of the Innovation Incubation. She read the third paragraph on the first page of the Executive Summary, which was included in the meeting packet, where it states "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.” She stated, as the Commission rolls out the Innovation Incubator and reviews comments and feedback on the first read of the report, it would be helpful for the Commission to track these areas to see transformation happen and to learn if future county Innovation plans will seek to meet those areas. It would be helpful to track how transformative Innovation plans become because of the Innovation Incubator.

Executive Director Ewing stated one of the points that will be discussed tomorrow during the strategic planning process will be how the work that the Commission does through these meetings and the work that the staff does under the Commission’s direction results in improved outcomes. The goal is to use the Innovation Incubator as a tool to drive transformational change.

Executive Director Ewing stated the Commission’s full attention has been on approving Innovations but there has been little to no discussion about whether those Innovations worked, the lessons learned, sustainability, and how to take them to scale. He stated there has not been time for those discussions. The hope is to put more emphasis on impact through the building of these tools.

Executive Director Ewing asked Commissioners for their input on the Establishing an Innovation Incubator component. He asked about the process to spend the \$5 million for the Innovation Incubator and about the elements Commissioners would like to include in the Innovation Incubator.

Royal Chukwudumebi suggested including public and private high schools, colleges, and school counselors into the membership for the Learning Community. She suggested including apps and websites in the products for the Learning Community. She stated most of the TAY and even some of the younger-aged individuals go through experiences. They would not want to use the term mental health problems because of the stigma, but they are going through a lot and would appreciate the products that would be produced with the Innovation Incubator.

Commissioner Brown asked Executive Director Ewing for his recommendation. There are a couple of options in terms of how the Innovation Incubator could be structured, such as universities and nonprofits being considered for the contractors. He asked if this is envisioned as being based out of the Commission and having contractors fill that role or if this is envisioned as being farmed out externally. He stated, even though it is a two-year model, it should be sustained. He asked about the best approach for doing that.

Executive Director Ewing stated the recommendation for the Innovation Roadmap is that a core group of Commissioners will participate in a subcommittee to hash out guidelines. For the Learning Community, the Commission would ask the Legislature for start-up funding of approximately \$3 million to \$5 million with ongoing funding in the same amount coming out of State Administration Funds for the MHSA to support this with a county match. The goal is for the Commission to decide in January or February because of the need to ask for the funding.

Executive Director Ewing stated individuals that have the capacity to do this need to be identified to get a sense of their qualifications and five to ten competitive proposals must be submitted that can be sorted through. He stated he does not have a strong sense of what the best way forward is. The two-step process is finding the right process for procuring this and determining what is being procured.

Commissioner Brown asked if the university- and nonprofit-based models were models with a mental health component or a business incubator.

Executive Director Ewing stated they were in the mental health space. There originally were five California Centers of Excellence funded by the federal government. The funding was withdrawn when it was determined that it were not the best use of limited resources. He stated this is a space where the four goals listed on page 1 of the Innovation Incubator Staff Summary could be focused on: provide strategic guidance, support technical assistance and training, enhance evaluation, and disseminate information.

Executive Director Ewing stated there are programs in California in the mental health space doing many of those functions. Some have been successful but none have been sustained beyond ten years. The funding that will be received over the next two years can be spent across five fiscal years while slowly pulling in county dollars to make it a sustainable initiative.

Commissioner Brown stated it sounds too nebulous to get a handle on. He stated he is trying to look at this as a business incubator model, where there is an individual who wants to start a business and get advice, expertise, and help along the way, perhaps even in a physical location where the business can start and have support. He stated the hope that this would not be given to another organization, but rather the staff – whether they are MHSOAC staff or contract staff – would be under the umbrella of the MHSOAC and perhaps physically housed or headquartered at the MHSOAC. He asked the Commission to be careful not to take the funding and then empower another organization to do what the Commission really wants to do.

Executive Director Ewing stated that has not been sorted through. In the discussions about this being a nonprofit model, it was suggested that three of the five seats on the board would be held by Commissioners, at least initially. In the discussions about this being a university-based model, it was suggested that there would be lots of structure involved in terms of the dollars being put into it to ensure that there is good alignment, particularly in the Innovation Incubator while facilitating the plan preparation that is intended to then be certified as meeting Commission standards.

Executive Director Ewing stated he had not thought about it being a function of the Commission. The Commission could enter a contracted-out model, but the civil service system does not lend itself to hiring staff to have this level of expertise at the right pay level. There would be challenges if this was a function of the Commission, particularly when the \$5 million is envisioned as start-up funds and the sustainable strategy is drawing in county money. The bias or default was something that was not in-house.

Commissioner Brown stated the problem with that is the counties that need it the most are the ones that do not have money to spend on something like this. He asked for additional information on what has been done in the past and what is being compared.

Executive Director Ewing agreed and stated this agenda item is meant to get feedback from Commissioners while at this junction before working on the process and product to ensure it is right.

Commissioner Mitchell stated it sounds exciting because the possibilities are so great if it is done right, but it is also frightening because of the possibility of wasting resources. She stated the two-step process of the Innovation Incubator and Learning Community is a great opportunity. She stated, although staff does great work, the workload is already to capacity. This is more of a contracted-out or university project with individuals with brilliant minds working with the Commission, but it takes the Commission helping to design the requirements and end product. She stated the Commissioners have to be visionaries and to think in terms of how this can be most beneficial for California and what is expected to be gotten out of it. Those two things alone make it a possibility, but it does have to be done correctly and with intention. It is a

two-step process. There are elements of it that are already completed; it is just a matter of trying it all together.

Executive Director Ewing stated it is \$5 million spread out over five years and, in that five-year period, the mental health system will cost the state of California approximately \$40 billion. There needs to be a broader discussion around the Innovation component and on how to calculate the return on not just the \$5 million but the \$100,000 million per year that is available for Innovation. The \$5 million is a small percentage of what is being spent now and much of that is not currently being spent effectively. These are the significant tensions that will be addressed through this work. There is nothing like this today mostly because there are no Innovation funds elsewhere in the country.

Commissioner Anthony stated she embraced innovation and the idea of conveying information between counties and having something that possibly is a goal for other states to achieve. She stated her only concern about the Innovation Incubator is to be careful not to relinquish any duties of the Commission to other bodies.

Public Comment

Steve Leoni stated the Innovation Incubator could also be a benefit to the Commission to get a clearer vision of what it regards as innovation and the direction to move. The speaker has heard that individuals see the MHSA as transforming the system, but questioned what that transformation means. The speaker asked what kind of transformation and from where. Early on, when the MHSA first passed, the then Department of Mental Health had many materials published online, which has all been removed. The speaker worked on a project funded with MHSA dollars with consumers and county mental health directors. That research was published but has disappeared.

Steve Leoni stated the need to define terms such as recovery. Many people say that recovery is when a person gets better or has no more symptoms or gets a job, but the heart of recovery is when a person gets their life back, when they get dignity as a human being back, which can include lots of different things. Recovery is when a person gets their humanity back. The speaker stated the hope that the Commission can look into this. The vision and mandates that are included in the code language are included by reference in the MHSA but this is never looked at.

David Nufer stated the Depression and Bipolar Support Alliance is strongly in support of this proposal.

GENERAL PUBLIC COMMENT

Poshi Walker asked that the general public comment be reinstated at the end of the morning session.

Poshi Walker stated representatives of the stakeholder projects do not only attend meetings. She stated #Out4MentalHealth is running task forces in all the mental health regions on the ground with local advocacy. Part of who they are working with are the individuals affected from the fires, including LGBTQ individuals who have a problem with emergency housing because oftentimes it is done by religious organizations that are not affirming of LGBTQ identities. The speaker stated #Out4MentalHealth does technical assistance and trainings, is working on a report with recommendations called the State of LGBTQ Communities, and did local research with counties around SOGIE data collection. #Out4MentalHealth also submits quarterly reports, the last of which was 800 pages long. The speaker thanked the Commission for their support.

RECESS

Vice Chair Aslami-Tamplen recessed the meeting at 4:06 p.m. and invited everyone to join the Commission for Day 2 of the meeting tomorrow morning at 9:00 a.m.

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
November 15, 2018

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

Members Participating:

Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck

Senator Jim Beall
Itai Danovitch, M.D.
Mara Madrigal-Weiss

Members Absent:

John Boyd, Psy.D., Chair
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo

David Gordon
Gladys Mitchell
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

DAY 2: November 15, 2018

RECONVENE AND WELCOME

Vice Chair Khatera Aslami-Tamplen reconvened the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Strategic Planning

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Session to order at 9:06 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll; a quorum was not achieved.

Executive Director Ewing provided a brief overview of the strategic planning process to date. He stated the early part of the day will be devoted to responding to Commissioner and stakeholder questions about the Commission's authority. He stated the law is specific about the functions of the Commission, but there are provisions that are intentionally nonspecific about how to accomplish its tasks. The activities of the Commission over the past few years have been structured to draw upon the range of authorities of the Commission and connect them in ways that drive change.

Executive Director Ewing stated today's meeting will focus on responding to questions that have been raised around why the Commission does what it does and where the Commission's authority is in terms of the statute and structure. Commissioners will be engaged in a beginning conversation on the Commission's effectiveness and how it can be strengthened.

STRATEGIC PLANNING DISCUSSION

Presenter:

- Susan Brutschy, President, Applied Survey Research

Susan Brutschy, President, Applied Survey Research (ASR), introduced the members of her team and reviewed the agenda, plan, and goals for the day.

Ms. Brutschy stated the ASR team is the Commission's ally. The role of the ASR is not to research state agencies, but to look for patterns and shared agreements to heighten communication and bring clarity of purpose and understanding to help the Commission communicate the difference it is making so everyone understands what success looks like. She reported the key finding that individuals want to be involved in this results-based strategic planning process and agree that it is the perfect time for the Commission to engage in a strategic planning process.

Ms. Brutschy introduced and thanked the members of the Strategic Planning Design Team who support the ASR throughout the process to help review feedback received and help the ASR to distill the massive amounts of information gathered during the strategic planning process. She thanked Commissioner Ashbeck, the lead of the Strategic Planning Design Team, for giving advice on the process, order, and structure and how to ensure alignment of understanding.

Ms. Brutschy updated the Commission on the progress and status of the MHSOAC strategic planning process and engaged in a facilitated strategic planning discussion. She began her slide presentation by reviewing the Process Map shown at the September meeting and noting what has been completed and where the Commission is in the four-step process outlined on the Process Map slide.

Initial Check-in Question

Ms. Brutschy asked Commissioners today's initial check-in question to ensure that everyone began the meeting on the same page:

What have you been thinking about in terms of this strategic planning process and the stories you want to be telling of the Commission's work?

Commissioner Ashbeck:

- This is the right thing to be doing.

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- The strategic planning process will be an important foundation to get the Commission where it needs to be.

Vice Chair Aslami-Tamplen:

- The purpose of the Commission is to oversee California's mental health services beyond the Mental Health Services Act (MHSA).
- The Commission has not tapped into three-quarters of the mental health services that impact communities.
- Consumers are re-traumatized in some parts of the system. It is important to ensure this is not being ignored.
- There is a need for improvements in the hospital system.
- There is a need for private insurance to step up in serving individuals with mental health issues.
- These things work together to ultimately help improve the services and outcomes for the individuals the Commission serves.

Commissioner Alvarez:

- It is important to consider Commissioners' responsibility and how to partner with communities in holding systems accountable.
- It is important to ensure that the Commission's vision of success matches that of the public that it serves.

Commissioner Madrigal-Weiss:

- It is important to consider where students and youth intersect the other systems.
- It is important to consider that mental health advocates are working toward common goals but different language is used to define those goals.
 - The Commission could help align those things better.
- The Commission could set metrics and define standards for county Innovation plans based on what has already been learned.

Commissioner Danovitch:

- The diversity and size of California makes it difficult to know where to focus.
- Simplifying this to the level of actions that can be taken is imperative in order for the Commission to have an impact; this involves determining values to decide where and what to act upon.

Commissioner Anthony:

- The Commission needs to think about what is possible in the future.
- It is important to be inclusive, which means including appropriate outreach and community engagement for this process and monthly activities.

Ms. Brutschy stated each Commissioner mentioned a theme that was a large takeaway from the initial ASR interview process. She stated it is nice to hear these themes being echoed over and over again. She asked meeting participants to introduce themselves.

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Recap

Ms. Brutschy provided a brief summary of the strategic planning process to this point.

Meeting Goals

Ms. Brutschy stated the focus of the rest of the meeting will be finding patterns of agreement and what they look like. She stated Commissioners will work on the following:

- Role and purpose
- Core values
- Short-term and long-term desired results
- Valued efforts

MHSOAC Framework Presentation

Executive Director Ewing stated Commissioners have asked questions and raised issues around the Commission's authority. He provided an overview, with a slide presentation, of the strategic planning process, current mission statement, components of the MHSA, statutory authority, budget, and strategic integration. He stated his goal in giving this presentation was to clarify the Commission's authority, show how it has been used, and demonstrate instances where the Commission has changed behavior and influenced outcomes.

Commissioner Questions and Discussion

Commissioner Ashbeck asked about the difference between the Commission's statutory authority to provide technical assistance under the Welfare and Institutions Code (WIC) Sections 5830, Review and Approve Innovation Plans, and 5846, Provide Technical Assistance, which were listed on Slides 7 and 8.

Executive Director Ewing stated the statute provides that the Commission can offer technical assistance but does not itemize in what context.

Commissioner Alvarez stated the issue of stigma continues to be a priority for Commissioners and members of the public. She referred to WIC Section 5845(d), Develop Strategies to Overcome Stigma and Discrimination, on Slide 9 and asked, although it is difficult to measure educational campaigns, if the Commission is trying to identify the impact and return on investment of stigma and discrimination campaigns.

Executive Director Ewing agreed that it is difficult and, because of that, the impact and return on investment have not been measured. It is sometimes too expensive or difficult to draw connections between the investments and the resulting impact.

Vice Chair Aslami-Tamplen stated there is much that can be learned from the research on stigma and discrimination reduction of mental health done by Dr. Patrick Corrigan. She stated his primary method that is most effective is the targeted local continuous credible contact with consumers. She stated that shifts attitude in meaningful ways in the long run. She stated there could be ways to learn from the fellowship program or the Art with Impact program, which require local effort.

Commissioner Danovitch referred to WIC Section 5845(d), Refer Critical Issues on County Mental Health Performance to the Department of Health Care Services (DHCS), on Slide 10 and asked about the meaning of that statutory authority and if it would be possible not to have statutory authority and still be able to refer something to the DHCS.

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Executive Director Ewing stated the law sometimes gives explicit authority to do things that can be done without that authority. He gave the example that the Commission could have engaged the business community to develop workplace mental health opportunities without explicit authority. The explicit authority validates and affirms in that instance because that is something the Commission could have done under general authority. WIC Section 5845(d) clarifies that, if the Commission notices an issue of critical concern, the proper procedure would be to signal the DHCS. He stated the Commission does this periodically.

Commissioner Ashbeck asked if the Commission's statutory authority is over everything a county does or just relative to MHSA dollars.

Executive Director Ewing stated this is a point of tension. The MHSA says to reduce school failures, criminal justice involvement, and unemployment but does not expect that to only occur with MHSA funds. These are not traditional mental health goals; these are wellbeing goals and quality of life issues.

Executive Director Ewing stated he sees the MHSA as recognizing that mental health is foundational to individuals being safe and healthy while working or in school, living at home, engaging with family and community, and being productive, but care is accessible, appropriate, and effective, when required.

Executive Director Ewing stated some portions of the law, such as WIC Section 5845(d), specify "that receive MHSA funds," while others are not specific. Part of the issue is that some individuals feel the Commission's authority is only over MHSA dollars. He stated the dollars are important but the policy is even more important. The policy is about preventing outcomes that are well beyond clinical care or what can be done solely with MHSA funds.

Commissioner Ashbeck agreed and stated another way to say it is the MHSA is not just about the money; it is about the system of care.

Commissioner Anthony asked if WIC 5845 includes the DHCS and their policies that are currently in place.

Executive Director Ewing referred to the last box on Slide 8, Advise the Governor and Legislature Regarding Actions to Improve Care and Services for People with Mental Illness, and stated it does, given that the DHCS has the programmatic, compliance, and audit oversight components. He stated his interpretation of WIC Section 5845 is that the Commission can advise the Governor and Legislature on any action that will improve care and services for mental illness, including the responsiveness, appropriateness, and adequacy of federal law, state programs and practices, the DHCS, the California Department of Public Health (CDPH), and the California Department of Education.

Commissioner Alvarez referred to Slide 12, Budgetary Authority, and asked about the opportunity for the Commission to ask the Legislature about their plans for funds, and about the Commission's responsibility to have oversight of funds when there is an allocation of MHSA dollars through Legislature-identified priorities.

Executive Director Ewing stated, because the Commission has the authority to advise the Legislature, it has the opportunity to advise the Legislature on giving the Commission the budget authorities. He gave the example of asking the Legislature for the \$5 million for the Innovation Incubator. The Commission has the opportunity to shape one-time specific authorities and to change the Commission's statutory authority. Advising the Governor and Legislature can include changes to the Commission's statutory authority, which can include asking them for budgetary authority.

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Executive Director Ewing stated this gets more challenging when asking the Legislature about oversight because the Commission would be asking to oversee itself. The Governor's office, the Legislature, the Department of Finance, and the Little Hoover Commission oversee the Commission. The Commission is subject to audits and reviews. The broader question was asked in yesterday's Commission meeting and Commissioner Beall's response was that that rock was not fully polished.

Commissioner Alvarez stated her question was more about when the Legislature identifies the MHSA as a funding stream for a priority that the Commission did not know about. She asked if the Commission is invited to ask the Legislature more about the priority and how the Commission will be involved, particularly as it relates to meeting the mission.

Executive Director Ewing stated the Commission can ask for more information similar to the Commission asking the DHCS to explain why they wrote a letter to the counties suggesting that they do not need to spend their MHSA funding within three years even though it is mandated in law, but that would not be typical. The Commission does not have oversight authority over the Legislature. He stated typically the Commission identifies areas that need additional attention, such as the policy projects. The Commission made recommendations to the Legislature and, in that example, they were responsive. He stated, instead of the Commission disagreeing with the Legislature's funding decisions, the Commission points out missed opportunities.

Commissioner Danovitch asked if the statute implies a limit or scope of what is statutorily under the responsibility of the Commission.

Executive Director Ewing referred to Slide 14, Broad Authority to Accomplish its Purpose, which included the statutory language from WIC Section 5845(d). He stated WIC Section 5845(d) gives broad authority and wide discretion to the Commission to do what it needs to do to be successful.

Commissioner Danovitch asked about the relationship between the Commission and the DHCS and if the statute discusses the Commission's domain versus the DHCS since there are many tension points between how the two entities relate and how that enables the Commission to do what needs to be done.

Commissioner Danovitch asked why the main focus is on the DHCS when there are many other departments that are under the California Health and Human Services Agency (CHHS) and strongly relate to the Commission's mission and goals.

Executive Director Ewing stated the emphasis is on the DHCS because people often see in some cases a conflicting and in other cases a duplicate role. There are areas where both entities do data analysis or have oversight authority. There have been conversations to clarify but it would be time intensive and nonproductive. He stated the Commission's authority is broad with tremendous discretion.

Commissioner Beall clarified that the context of the relationship between state government agencies is similar to what happened during the budget crisis of 2010-2011, when MHSA funds were given to various state departments to reimburse their expenses of providing services to the MHSA. He stated his review of the budget shows that those departments receive funding for various things. There is a conflict there because those departments are needed for the things they do, but they are under no obligation to report how they are spending the funding. He stated there are many individuals who would like to look at that now that the budget has a \$26 billion surplus. Funding was given to specifically-identified departments at the passage of Proposition 63, but additional funds were added. He suggested exploring the history of that.

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Commissioner Ashbeck stated she wondered if the attention on innovation has caused individuals to lose sight of the basic programs of mental health intervention such as the full-service partnership (FSP). She stated the fact that only 38 percent of FSPs are meeting their goals, which creates accountability tension. It is not acceptable for counties to continue spending millions of dollars on FSPs, when less than half of the individuals enrolled in FSPs reach their goals. There is tension between holding individuals accountable and funding new, interesting things. If less than half the individuals enrolled in FSPs reach their goals, those individuals either have the wrong goals, the wrong FSPs, or they need something else. She stated the state should not continue to fund individuals in FSPs just because that is what has been done in the past.

Executive Director Ewing stated concerns like Commissioner Ashbeck's are the purpose of this conversation. Commissioner Ashbeck's question, stated another way, is why spend so much time on Innovations if the core strategy is ineffective? Executive Director Ewing stated the answer is because the Commission is mandated to approve Innovation plans and there is a queue. He stated the Commission's greatest constraint is time. There is no time for the Commission to engage on FSPs or review the success rate of Innovations. He suggested including a consent process and clarifying those rules so the Commission can continue doing Innovation approvals.

Executive Director Ewing asked Commissioners what the most valuable use of their time is that will bring the most efficiency to the Commission in driving transformational change. He stated he was unsure that the mix that the Commission has at the moment, which is driven by the statutory requirements and the recognition that these Innovation dollars were not being spent, is as effective as it could be. The reason for today's meeting is for Commissioners to think through those issues.

Commissioner Ashbeck agreed that that is the opportunity through the strategic planning process and it can structurally get there by changing agendas, etc. She stated the Commission's time is spent focusing on spending Proposition 63 dollars through Innovation plans and policy work, but she stated she had never linked it to the FSPs. She stated that was an aha moment for her that in some ways was horrifying because the Commission can work on the surface but, if there is nothing inside, the work does not matter. She suggested the Commission take the opportunity to do the work better instead of taking on new and fancy things.

Executive Director Ewing agreed and stated the Commission recently got the FSP data and did the analysis but there is an argument as to whether that is the Commission's responsibility. He stated more than 50 percent of Community Supports and Services (CSS) funds are supposed to be spent on FSPs, but the analysis of the data is that they are not. The DHCS has performance contracts with the counties and fiscal oversight. He asked if this is an issue where the Commission should alert the DHCS of the concern and ask them to fix it or if the Commission should take this issue on itself. He stated this is the grist for the Commissioners to engage in today and moving forward to be the most effective body to drive change.

Commissioner Danovitch stated he strongly agreed with that concern. He stated there are many structural problems, such as issues with hospital beds and the availability of conservators and emergency services that directly impact individuals and communities that are core to what the Commission needs to get done. There are insurance issues around the lack of parity, essential health benefits, and mental health services. He stated the Commission cannot boil the ocean, but having a clear-eyed view of the structural problems and selecting among them the ones where the Commission can have an impact will enable the Commission to balance a realistic

view of the challenges that are out there and serve the function of communicating and disseminating information about that to increase awareness of those problems while also not diffusing and diluting the Commission's ability to have an impact given the narrower scope of what the Commission is able to directly do through its working projects.

Executive Director Ewing stated this is exactly the discussion the Commission should be having today – to see the whole context and to think about how Commissioners spend their time, in part because of the review and approval requirement and the unspent funds, but now is the time to revisit, rethink, restructure, and enhance. He asked Ms. Brutschy to walk the Commission through the next conversation.

Ms. Brutschy stated it will take ongoing work to answer the question about the way the Commission is working and how to maximize its impact. It is important for everyone to understand the complexities and tensions, where they are real, and where they can be changed. She stated she wanted to check in with Commissioners again before going further for direction, guidance, or questions to try to expand on some of the issues that were raised.

Commissioner Check-in Questions

Ms. Brutschy asked Commissioners the following check-in questions:

What else is coming up for you?

Is there something that needs to be attended to more specifically?

Commissioner Ashbeck:

- It is important to learn what the relationship with the counties should be.
- It is important to learn more about performance measures on the basics of mental health service delivery.

Commissioner Ashbeck stated Vice Chair Aslami-Tamplen used the word “local” when she discussed Dr. Corrigan’s work, but all of this is local. This only works because individuals live where they live. That is a huge element of that relationship with the counties and performance metrics are important in all of this. She stated she felt bad because, while Commissioners have been funding interesting innovations, she never thought to ask if the county’s basic structure of mental health is working for the community.

Commissioner Danovitch:

- Structural problems are local and addressable but they get perpetuated because of deep dysfunction and misunderstandings of who is accountable for services.

Ms. Brutschy stated one commonly-appreciated possibility and role of this Commission is to transform mental health services in the state of California, yet those services are delivered through the entity of the localities. The distinction and the understanding of what is currently happening with that relationship and what is possible came up many times during the initial data collection component of the strategic planning process. She stated it is understood differently in all the roles and ways that individuals engage, but this tension is quite real. Important work needs to be done.

Vice Chair Aslami-Tamplen provided a broader history and background perspective of consumers and how consumers came in contact with the mental health system prior to the Lanterman-Petris-Short (LPS) Act of 1967.

- It is important that the health system prioritizes “do no harm” first.

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- It is important to consider the kind of hospital beds and support that are needed. Currently, all support is cut off in psychiatric emergency rooms. Individuals in crisis have not committed a crime, and yet they are generally transported to emergency rooms by law enforcement at a time when they need care, support, and compassion. It is sending the wrong message.
- Individuals may choose not to receive California's great services because the above is what they are exposed to during times of crisis.
- It is important to create beds that are voluntary and welcoming. Consumers must be allowed to have their support with them similar to what is experienced with other health issues. Currently, it is not the same when it comes to individuals with mental health issues.
- The process needs to be improved. No matter how many great things the Commission adds, the core issues remain unaddressed.

Ms. Brutschy stated her team heard much about the core issues, the recovery model, and how important that was. She stated she also heard about the tension between the counties and the state and to look closely at the Commissioner time and resources to ensure they are allocated appropriately.

Commissioner Alvarez:

- Do not take lightly how difficult it is to break down silos.
- The Commission cannot hold counties accountable with their relationships between the CDPH and the DHCS, when the Commission is not even clear what its relationship is with the DHCS.
- The Commission is perpetuating the silos by not clarifying its relationship and shared goals with the DHCS.
- There is an opportunity in the broader health delivery system reform conversation around moving upstream and incorporating a whole person approach to delivery of care. Those conversations are happening, but they are happening within the siloes without integrating partners.
- Take the opportunity during the strategic planning process to be challenged, to step outside of comfort zones, to look to partners, and to help the DHCS more broadly in order to achieve overall wellbeing for California.

Ms. Brutschy thanked Commissioner Alvarez for pointing out the importance of shared understanding. She agreed that, although the strategic planning process will not make everything perfect between now and May, it can highlight where there is agreement and next steps.

Commissioner Madrigal-Weiss:

- Commissioners hope each new Innovation plan will make a change but are now learning that what they had hoped would make a change is not working. This is failing consumers.
- There is a greater sense of responsibility and urgency around the Innovation plan process because learning to influence what is already happening in counties is important in order to get to what is working.

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- Work more closely with the DHCS to hold counties accountable and get better, more accurate data back sooner.
- Do not continue to expand and extend without outcomes.

Ms. Brutschy stated this has been framed as a result-based strategic plan. The results are the answer to understanding what counties and partners can be held responsible for.

Commissioner Beall:

- In the current political environment, the Governor needs to hear what a good system of mental health would be, as he intends to do a large amount of work in mental health.
- Work with coalition partners on an ideal system for California – simple, easy for consumers to understand, immediate access, a continuum of care, intolerance of disparities, and appropriately staffed.
- It is important to learn how to encourage people to build up the mental health workforce.
- It is important for the Commission to keep unified values and take the opportunity to make change.

Ms. Brutschy stated a visual would be presented later in the meeting that attempts to categorize the big picture for a shared vision.

Commissioner Beall stated people learned a lesson in the latest election in California – if everyone can be included, they can form an incredible political coalition. It is California's responsibility to take the opportunity that has been presented.

Commissioner Anthony:

- Sharing views, making systems change, and taking opportunities to move forward are exciting.
- Remember to hold the Commission accountable to collaborate, cooperate, reach overall goals, and continue to focus on individuals.

Ms. Brutschy stated this conversation was completely different from two months ago, and the opportunities and vision of integration are becoming clearer. She encouraged Commissioners to pay attention to the commonalities. The Commission is in such alignment regarding challenges and opportunities that deeper discussion is possible already.

Next Phase: Methods Used

Ms. Brutschy stated the next phase will be to share some of the comments and opinions gathered during the strategic planning process to date. She continued her slide presentation and discussed the methods used for gathering information, process, profile of respondents, and summary of themes gathered. She stated only approximately half of the comments and suggestions will be shared today; the rest will be shared later during deeper discussions.

Ms. Brutschy stated the high-level takeaways from the comments and suggestions gathered to date were as follows:

- Transformation
 - Everyone understood this opportunity for transformation – to transform systems and to transform care that is being received.
- Principles

- There was a lot of agreement about the principles and the importance of the principles, though there was disagreement sometimes or a lack of understanding about what those principles were.
- Shared Language
 - Many times, the ASR team could sense the expression of what was being shared, but the different terminologies and language were reflected where the respondents were coming out of their own experiences.
 - The shared language is an opportunity for an “easy win” to tighten up language, not only internally but externally.
- Driven by Results
 - The Commission and Commission partners want to be able to tell the difference being made, to hold themselves accountable for outcomes, and to ensure that things are being done in the way that is appropriate and will make a difference.

Ms. Brutschy stated everyone has a different idea of what those outcomes could be, but the commitment and shared results was a common theme. She stated that is why she wanted to spend time setting a common stage about what is required of the Commission and the opportunities that are available for the Commission and its partners before going into the details.

Ms. Brutschy stated there are many background specifics for each of the themes – the purpose and role of the MHSOAC, the four core functions, and the perceptions of higher valued work of the MHSOAC. She continued her slide presentation by showing slides for each of the themes, beginning with Slide 10, the Purpose and Role of the MHSOAC. The slides contained the number of mentions or the number of times these items came up during the initial ASR interview process.

Ms. Brutschy stated the Commission tasked the ASR to point out the commonalities. She stated there was much agreement at the highest level about the importance of transforming systems, accessing care, and supporting communities that is in the spirit of the law. She asked how the Commission can measure and do the things that it wants to do about outcomes and leveraging and potentially reducing or modifying the way the Commission spends its time, dollars, and resources without that commonality. She asked Commissioners the following question:

What do you think about this disconnect and what advice can you give the ASR to keep on going with the strategic planning process while knowing that the language is vague in terms of the partners and fellow Commissioners?

Commissioner Ashbeck stated she was trying to draw a picture of what it looks like. She stated it would be helpful to have a logic model or roadmap of the MHSOAC Organizational Roadmap, which was included in the meeting packet. She stated the roadmap of the Roadmap would include all mental health spending and the elements of the MHSA, such as prevention and early intervention, etc.

Commissioner Danovitch stated the MHSOAC Organizational Roadmap was created for the strategic planning process. There are strategic integration examples mentioned by Executive Director Ewing, which are examples of successes. He asked how to map out a destination and orchestrate policy, transparency tools, partnerships, and innovation mechanisms to try to have a clear impact, and then, also, how to evaluate and monitor that.

Commissioner Danovitch stated the need for discussions and decisions on which outcomes to focus on and what roadmap to take to get to the destinations in order to effectively track outcomes.

Ms. Brutschy stated there is a next step roadmap that will be shared later in the afternoon.

Commissioner Ashbeck stated the importance of focusing on continuous improvement of the core elements of mental health systems of care in California. There are models that could be applied to improving the core while also doing Innovation. It is a great opportunity to fulfill the obligation to build a solid foundation for future Innovation.

Ms. Brutschy stated, depending on the category, there is a difference in feeling about the tension between counties, the state, and the Commission. The county relationship is pivotal, and the way out is to focus on results, principles, and the populations.

Commissioner Check-in Questions

Ms. Brutschy asked the following check-in questions:

Do these themes match your understanding of what is important?

Is there something missing in those themes that Commissioners wanted to ensure did not get lost?

Are there other suggestions about this tension and about the overwhelming commonality and agreement about where the Commission is right now and the possibilities?

Is there anything different than what was expected to be found from that wealth of information?

Vice Chair Aslami-Tamplen:

- She stated she feels relief over discussing the bigger system instead of it continuing to be ignored.
- She stated she feels relief over discussing the core of when crisis happens and how to improve crisis response – that is also part of prevention, workforce, and CSS.
 - If that is not addressed, it is repeating trauma in the name of care – this is part of the resistance in wanting to seek services.
- The mental health system of care needs to move to using the model that hospitals use for urgent care so that mental health urgent care and intense care do not do more harm.

Ms. Brutschy stated she heard Vice Chair Aslami-Tamplen also say to look for the core and the central organizing scheme through all aspects heard today. She stated that was central to Executive Director Ewing's visual – that there are strategic, core themes that are linked through all of these and to ensure that the Commission is keeping its eye on care, doing no harm, and the recovery model.

Ms. Brutschy showed Slide 18, Theory of Change/Organizational Roadmap, the preliminary presentation slide for the afternoon session, for Commissioners to consider during the lunch break. She asked how the ASR should handle this while bringing people along at the largest level. The theory of change concept came up often during the initial ASR interview process in terms of telling the story of the roadmap.

Ms. Brutschy stated Slide 18 is an if-then statement – if the Commission does these things with these partners, understanding who has responsibility for what, then these results will be seen.

She referred to the MHSOAC Organizational Roadmap of the four core functions and the agreements of what success looks like. She stated this is the ASR's second effort of putting the information together that has been gathered so far during the strategic planning process.

Ms. Brutschy reviewed the MHSOAC Organizational Roadmap, which is a working roadmap for the Theory of Change/Organizational Roadmap slide. The right side of the MHSOAC Organizational Roadmap shows that everyone who needs care gets care in the right way and at the right time. That is the "then" statement of the MHSOAC Organizational Roadmap. The "if" statements are on the left side of the MHSOAC Organizational Roadmap, which are the four core functions, the organizational schemes where there is commonality, and a list of activities under each of the core functions.

Ms. Brutschy stated, in following this roadmap, the Commission, counties, and the state will improve how care is delivered. It is a beginning of communicating what the Commission does, why it does it, the ways it does it, and what success will look like in transforming systems with better outcomes for everyone in California.

Ms. Brutschy stated it is a different way of thinking and communicating. Once agreement has been reached and there is a shared understanding under each of the core functions, then the measurement and the dashboard become easier to understand because Commissioners have agreed and prioritized, are not measuring everything at the same level, and can tell the story of change. She stated the rest of the day will be devoted to continuing that conversation.

Ms. Brutschy asked for initial comments and observations of the review of the MHSOAC Organizational Roadmap and the Theory of Change/Organizational Roadmap slide.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen stated the conversation has been beyond only the counties. One of the challenges is the range of services available depending on location. She suggested changing the top green point in the middle column of the MHSOAC Organizational Roadmap from "counties will continuously improve access, quality, and outcomes" to "counties, health plans, and private insurers will continuously improve access, quality, and outcomes for mental health." She stated everyone needs to work together on this, not just county behavioral health care systems. Access needs to be improved for all kinds of health care.

Ms. Brutschy stated this issue has come up time and time again. The entitlement to the care individuals deserve has changed since the MHSA was developed.

Commissioner Danovitch thanked the ASR team, Commissioners, stakeholders, and staff for this valuable process. It is helpful to be able to have these conversations within the bounds of the Bagley-Keene Open Meeting Act. Often in meetings, questions of where to go become secondary without a plan for how to get there. The roadmap allows the discussion focus to return to where to go.

Ms. Brutschy stated individuals are seeking to align and leverage in these necessary conversations to achieve transformation. The ASR team is listening and open for improvement.

STRATEGIC PLANNING BREAKOUT SESSION

Vice Chair Aslami-Tamplen asked Ms. Brutschy to guide the Commission through the strategic planning workshop process.

Ms. Brutschy reviewed the afternoon agenda. She referred to the Theory of Change slide and highlighted Commissioner Danovitch's point about not only holding Commissioners accountable

to the outcomes but about changing the way the Commission works with its partners. She stated that is an exciting component in the Commission's theory of change.

Ms. Brutschy summarized that the morning session's larger questions were about the core functions, mission, value, and some of the principles of the MHSOAC. She stated certain topics and issues were brought up during the deeper discussion this morning that she wanted to pursue further:

- Prioritizing certain sets of activities and questioning which were of greater or lesser value.
- The Commission's priorities and what they look like.
- The information gathered during the initial ASR interview process looked different from the conversations the Commissioners began having during today's morning session.

Ms. Brutschy continued her slide presentation by discussing the most and the least commonly-valued activities of the MHSOAC. She noted that the question about the most- and least-valued activities was different from the others asked during the initial ASR interview process in that it was not open-ended. Respondents were asked to select from a closed set of responses. The slides contained the number of times each response was selected.

Ms. Brutschy also noted that respondents often stated the response they selected as the activity with the least value may be because of the following:

- Respondents did not understand them as much as the others.
- Respondents questioned whether certain activities were in areas where the Commission had expertise.
- Respondents did not understand where focused collaboration and communication existed within those projects.

Ms. Brutschy stated the ASR began having conversations and collecting information about results and strategies but there was such a lack of clarity about what the higher-and lower-value projects were that the ASR team wanted to have a conversation with the Commissioners prior to talking about strategies and results. It is difficult to get to the results when the goal of the project is not understood. Suggestions for strategies, improvements, and measurements will come after the ASR begins filling out the Theory of Change chart.

Ms. Brutschy asked Executive Director Ewing to comment.

Executive Director Ewing stated the ASR team is trying to learn if this is a communication challenge or a lack of awareness versus a valid and reliable discussion of priorities. He gave the example of the Fiscal Transparency Tool as an activity that is highly valued in the Legislature, among stakeholders, and others. He stated it struck him as odd that evaluation was the leading priority value but the presentation of the information, which is what the Fiscal Transparency Tool is about, was the least valued. He stated he questioned how different stakeholders viewed the different components in terms of prioritization. He stated it would be helpful to get a sense from Commissioners of how they think about these priorities.

Executive Director Ewing stated there was a tension between understanding the frustrations in the current mental health system and what needs to be done. That needs to be paired with the Commission's authority and tools and with the incredible opportunity that the Commission represents. He stated the Commission has a long way to go to reach its potential. Commissioners need to consider the current tools, the need for additional tools, and how

Commissioners' time is used. The effectiveness of the core functions is the opportunity for Commissioners to begin identifying priorities and how to move forward.

Commissioner Danovitch stated it was helpful to get feedback. One of the issues that it makes apparent is that both process activities and issues or problems have been categorized in this exercise. That comingling of activities and issues is confusing. He suggested that, when discussing prioritizing, the Commission may want to prioritize the issues or problems such as suicide prevention, addressing substance use disorder, the hospital bed crisis, school dropouts, or homelessness. He stated many activities may be required for each of the issues prioritized, such as transparency tools, workplace interventions, and fellowships. He stated guidance from Commissioners and stakeholders is needed on the issues that are important, and then the activity questions can be answered from the perspective of a particular issue.

Commissioner Check-in Question

Ms. Brutschy asked Commissioners to share their thoughts and ideas about the following check-in question in preparation for the upcoming group discussion.

Does this match your understanding of which MHSOAC activities hold the most value?

If not, talk about what you view as the most important activities for the MHSOAC to be successful.

Executive Director Ewing asked Commissioners to recognize that not everything the Commission does may be reflected in the list of the three greatest and the three least commonly-valued activities listed on Slides 20 and 21.

Ms. Brutschy agreed and stated everything on Executive Director Ewing's presentation is on the left-hand side of the Theory of Change chart. She stated the comingling is happening there even more.

Commissioner Anthony:

- This morning's discussion provided enlightenment. She stated she now has a hopeful feeling that the Commission can move forward with a broader scope and lens when looking at issues, and can keep the overall goals in mind while working on the objectives needed to achieve those goals.

Ms. Brutschy summarized that Commissioners feel empowered and emboldened.

Vice Chair Aslami-Tamplen:

- Broaden the evaluation activity to an evaluation of the whole system of care in California, inclusive of private insurers and health plans.
- This goes hand-in-hand with community engagement, which is the number two most commonly-valued activity.
- Review and approval of Innovation plans is about streamlining the process by working with the Innovation Subcommittee and the counties to submit their Innovation plans in line with the Commission's expectations.
- There are legislative ideas that can help the Commission get to the vision of transformation and wellbeing for all.
- The quality of services and the rights of the individuals within those services are critical.

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- Crisis services need to improve.
- Hospital systems need to take seriously the concerns brought up by consumers in those settings.
- Those are important factors that should be part of the Fiscal Transparency Tool including the following:
 - The number of seclusions and restraints that are happening in locked facilities and the plan to eliminate that.
 - Ensure individuals that, when they have concerns about their rights, there is a patient rights advocate there for them advocating and supporting them to address their concerns while they are in critical care.

Commissioner Alvarez:

- She was encouraged that the general comments of the respondents are that they see the Commission's responsibility to be oversight and accountability of the system as a whole and, from what the respondents identified as most commonly-valued activities, evaluation rises to the top.
- The Commission evaluates the system's ability to meet the needs of California's residents; however, is that the definition that individuals used when selecting evaluation as the top value?
- One of the Commission's main evaluation tools is the Fiscal Transparency Tool, which respondents did not find effective.
- There is a clear disconnect between what respondents believe evaluation is and what the Commission believes evaluation is. Until that is clear, the respondents will never see the Commission as doing a good enough job and the Commission will never be held accountable to the public the way it should be.
- How are these things defined so that everyone will be moving toward the same goal?
- Encouraged that community engagement was second on the list of the most-valued activities. That reminds Commissioners of their responsibility to be present during community engagement opportunities.
- What does that look like moving forward?
- How should Commissioners work with staff to ensure that those opportunities are presented in a timely way so that Commissioners can be present to represent the Commission?

Ms. Brutschy stated additional work was done on the Fiscal Transparency Tool at yesterday's Commission meeting.

Executive Director Ewing stated an update was presented to the Commission yesterday showing the Fiscal Transparency Program Tool that provides basic information on 1,500 community programs and outcomes. He briefly reviewed some of the work being done, such as on the FSP data.

Commissioner Madrigal-Weiss:

- She agreed with Commissioner Danovitch on the need to break apart the activities and issues.

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- There is a need to focus on issues and come back to capacity, scope, definition, data, systems, and goals.

Commissioner Alvarez:

- The Fiscal Transparency Tool not only creates greater transparency but it allows the Commission, in partnership with stakeholders, to use those tools to make things better for individuals who need services.
 - One of the Commission's greatest tools in oversight and accountability is the relationship with stakeholders. The Commission is supposed to be partners in the work to oversee the mental health system. It is that partnership that allows the Commission to hold the counties or other entities that are delivering mental health services accountable.
 - Part of the Fiscal Transparency Tool is to give stakeholders the data they need to hold counties and the system accountable.
 - That partnership can be strengthened by clarifying that those tools exist and that they see as much value in this data as the Commission does in presenting it.

Commissioner Anthony:

- She added to Commissioner Alvarez's point the importance of communication and getting the word out that the Fiscal Transparency Tool is available.

Commissioner Madrigal-Weiss:

- Also get the word out about the Fiscal Transparency Tool at the county level.

Ms. Brutschy summarized the points of focusing in on the day job and Innovation, keeping an eye on the local and state levels, and dividing up between issues and activities.

Executive Director Ewing reinforced the comment about the county. He stated the Fiscal Transparency Tool was not designed to provide information to the Commission; it was designed to create public accountability. He gave the example of a 20-page County Revenue and Expenditure Report. He stated those 20-page reports over five years would be 100 pages. Multiply that times 59 counties and that would be 5,900 pages. The Fiscal Transparency Tool makes the information contained within those 5,900 pages point-and-click easy to see.

Ms. Brutschy stated the conversation will continue during the workshop about the core functions and Innovation with a subtext of issues with explanations of why they are important to help Commissioners understand why and what that would mean while toggling back and forth between the county and the state.

Ms. Brutschy stated meeting participants will be randomly assigned to tables with a scribe at each of four tables for the afternoon workshop of facilitated conversations. She asked everyone to count off from one to four to divide up into four 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 Commissioners to give their final comments now that they have engaged with the big topics and small groups.

Commissioner Anthony:

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- The need for accessibility during evening and weekend meetings for individuals who cannot take time off from work to attend.
- Oversight and accountability comes down to innovation and transformative change.

Vice Chair Aslami-Tamplen:

- The core system of care utilizing a strong preference of voluntary and trust-building services and activities as a first choice in services is critical to reaching true wellness/recovery/resiliency model services.
 - That approach overall not only reduces stigma and discrimination, it covers PEI and all services that should be the Commission's guiding light.
 - That approach needs to be at the forefront when looking at the core system of care and evaluating it.
- Transformation will be seen throughout the state when consumers and family members are involved in employment at all levels throughout the system – not just the county system but the managed care system and private insurer system.

Commissioner Alvarez:

- There is a critical importance of community voice in making decisions along with the Commission and holding space and power in the work the Commission does to support mental health access across the state.
 - The law as written is not necessarily being followed, and the mechanisms to hold the counties and the state accountable to meaningful community engagement are not necessarily as strong as they could be.
 - Identify pathways to strengthen consumer input as a critical way to ensure that the Commission is doing its job.
- Challenges associated with the workforce fundamentally relate to access barriers for individuals in California and what it means with regard to priority setting around training opportunities, education, and identification of alternative models for workforce.
 - Both long-term and short-term solutions around workforce need to be identified.
- Utilize existing Commission partners to strengthen overall efforts, such as local planning boards, stakeholder contracts, and others, in order to work together toward shared goals.

Commissioner Danovitch:

- There is a need for accurate population-level surveys to identify the needs of community members, particularly members of the community who have traditionally not been well-served, and as a basis to evaluate change.
- There are issues around emergency department boarding, which is a final-common-pathway-type problem that has many contributors to it, and the data, which is measurable and available on a county-by-county basis.

Commissioner Madrigal-Weiss:

- It is important to reach out to the stakeholder groups the Commission represents at the county and state level.

MHSOAC Strategic Planning Session Minutes

November 15, 2018

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- Increase accountability to counties to ensure that consumers have equitable access to resources.
- Some counties mirror fiefdoms.

Commissioner Beall:

- Engage groups that maybe have not been engaged as much.
- Evaluate the evaluation.
 - Have a comprehensive way to do evaluations.

Executive Director Ewing:

- There is a need for improvement of technical assistance in key areas including community engagement.
 - It is unclear how that can happen.

Closing Statements

Ms. Brutschy summarized where the ASR is in the strategic planning process:

- The ASR is continuing to collect information and feedback. Contact the ASR with additional comments and ideas.
- The ASR is continuing to synthesize the information and refresh the Theory of Change chart.
- The ASR looks forward to pursuing shared understanding.

Ms. Brutschy stated she appreciated the Commissioners and thanked everyone for coming.

Executive Director Ewing thanked everyone for their participation and the ASR team for helping everyone through the strategic planning process. He stated there were discussions in the morning session that created clarity around the Commission's authority, what the Commission does, and how the authorities and what the Commission does are connected. The afternoon session started the conversation around priorities and becoming more effective in doing the work. He stated there is more work to be done but great progress was made today.

Vice Chair Aslami-Tamplen also thanked everyone for their participation and the meaningful, rich discussion throughout the day. She stated she looked forward to continued discussion and the focus on priorities.

GENERAL PUBLIC COMMENT

Bianca Gallegos, Mental Health America of Northern California (NorCal MHA) Advancing Client and Community Empowerment through Sustainable Solutions (ACCESS) Ambassador, discussed the trauma-informed training for the Berkeley project. The speaker stated one of the intended outcomes is to promote better mental health outcomes by increasing child and family referrals to appropriate mental health services. The speaker suggested that a peer specialist and other professionals be present during the trainings to answer questions and normalize it because some of the individuals in the trainings have never had prior contact with peer support specialists, psychologists, or members of law enforcement.

Josh Morgan, Psy.D., asked if it is possible that, based on evaluation, the outcomes being evaluated are unintentionally contributing to stigma and discrimination. The things discussed are

explicitly called the negative outcomes. Reducing emergency department utilization, hospitalizations, criminal justice involvement, suicides, and homelessness are important and need to be evaluated but, if those are the only things being discussed, then what is being reported is how individuals are being less of a “burden on society.” That is not the story to tell. The speaker suggested beginning to evaluate things such as social connectiveness and using measurements such as social support and volunteerism.

Vice Chair Aslami-Tamplen agreed and stated Alameda County created a project called Measure What You Treasure to highlight what peer services were about. The areas they first looked at and promoted were hope, personal empowerment, social connectiveness, a welcoming environment, and satisfaction of services.

Johana Lozano, NorCal MHA ACCESS Ambassador, thanked the Commission for doing such a great job on this daunting task. The speaker shared their story of living with a mental illness and not becoming a statistic. The speaker stated they were in attendance because of the good things the Commission has done. The speaker stated the hope that the Commission will continue to move forward and have these hard discussions. The speaker emphasized the compassion and empathy theme.

Commissioner Anthony suggested that everyone eat lunch together during Commission meetings. It allows Commissioners and stakeholders to communicate and bond.

ADJOURN

There being no further business, the meeting was adjourned at 3:13 p.m.

State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
December 17, 2018

Sacramento County Office of Education
10474 Mather Blvd.
Mather, CA 95655

866-817-6550; Code 3190377

Additional Public Locations

811 Wilshire Blvd, Suite 1000
Los Angeles, CA 90017

1544 Palos Verdes Mall Suite 44
Walnut Creek, CA 94597

7555 Van Nuys Blvd
Van Nuys, CA 91405

2 New Montgomery St
San Francisco, CA 94105

7775 North Palm Ave
Fresno, CA 93711

1144 Camino Del Rio
Santa Barbara, CA 93110

8730 Alden Dr, Suite E-119A
Los Angeles, CA 90048

1033 Fifth St, Yosemite Room
Clovis, CA 93611t

4434 Calle Real
Santa Barbara, CA 93110

3050 Beacon Blvd
West Sacramento, CA 95691

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Senator Jim Beall

Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Sheriff Bill Brown
Assemblymember Wendy Carrillo

Dave Gordon

Staff Present:

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

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 4:02 p.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd reviewed the meeting protocols.

ACTION

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

Filomena Yeroshek, Chief Counsel, stated that Commissioner Brown was not able to attend today's meeting and reminded Commissioners of Commissioner Brown's request made at the November meeting to reconsider the September 27, 2018 meeting minutes. Chief Counsel Yeroshek stated that Commissioner Brown requested on the record that pages 11, 12, and 18 of the September 27, 2018 minutes be amended to delete the incorrect statements that he and Commissioner Wooton left the room when recusing themselves.

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

The Commission approves the October 25, 2018 MHSOAC Meeting Minutes, and the September 27, 2018 Meeting Minutes with the following amendments: (a) Page 11, delete, "and left the room pursuant to Commission policy"; (b) Page 12, delete, "Commissioners Brown and Wooton rejoined the Commissioners at the dais."; (c) Page 18, delete, "and left the room pursuant to Commission policy."; and (d) Page 18, delete, "Commissioner Brown rejoined the Commissioners at the dais."

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

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

The following Commissioner abstained: Chair Boyd.

ACTION

2: City of Berkeley Innovation Plan (Extension)

Presenters:

- Karen Klatt, M.Ed., MHSA Coordinator
- Nina Goldman, 2020 Program Manager
- Anita Smith, Education Specialist, Head Start

Karen Klatt, M.Ed., City of Berkeley MHSA Coordinator, introduced the presenters, provided background and context to the City of Berkeley Innovation plan extension, and a brief overview of the proposed budget.

Nina Goldman, 2020 Program Manager, addressed Commissioners' questions asked during the November 2018 Commission meeting. Ms. Goldman outlined the key findings of the initial Trauma Informed Care project. As a result of the project, teachers became motivated and better understood the trauma informed care model. Teachers had a higher sense of advocacy and were much more comfortable working with parents when recommending students to seek counseling.

Ms. Goldman provided the key steps on the underlying theory of change. Trauma has a significant impact on Headstart students and staff. Introducing a trauma informed approach to the program will

enable them to recognize their own trauma and triggers. The questions students are asked will be shifted from “what’s wrong with you?” to “what happened to you?” Teachers and staff will be able to develop informed relationships with parents and guardians. This will lead to more appropriate mental health referrals.

Ms. Goldman provided an overview on the questions outlined in the original Trauma Informed Care plan and the four outcomes City of Berkeley is hoping to achieve. The details on the evaluation are not available because the Request for Proposal is being written and will be finalized if the Commission approves the funding.

Commissioner Discussion

Commissioner Mitchell appreciated City of Berkeley’s presentation for this meeting. Commissioner Mitchell asked for clarification on the shifting of the program from Berkeley Unified School District to the YMCA. Nina Goldman explained that the YMCA oversees the Headstart program in the City of Berkeley and reaches many students in low income families and members of diverse populations.

Commissioner Wooton appreciated City of Berkeley for answering the Commission’s questions in this presentation.

Commissioner Alvarez asked about the process of referrals in regards to the sensitivity and the hand off to the YMCA. She also asks about the opportunity for other counties to learn from the City of Berkeley.

Anita Smith explained that the referrals are primarily done within a case consultation setting where the consultants, teachers, and parents are all working collaboratively. There are several mental health agencies within the City of Berkeley that parents can be referred to for assessments. Parents are given all of the information to take responsibility as they hold the consent of the children. Afterward, the county will follow up with the agency to ensure that the agency and parent were able to connect, as well as being a further resource if needed. Ms. Smith explained the sustainability component in that the county will be training program staff to be mental health consultants. They will be training the trainer and the YMCA is in other counties.

Commissioner Ashbeck asked Commission staff when a plan extension becomes a new program. Brian Sala, Ph.D., Deputy Director, explains that the regulations do not clearly state what constitutes a new project versus what is an amendment to an existing project. Deciding when a plan is a new project or an amendment is left to the purview of Commissioners. This allows Commissioners to reflect on what is an appropriate amendment to an existing project. There are however specific language on when a county must come to the Commission to amend a project.

There was no public comment provided on this agenda item.

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

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

Project Length: Five (5) years

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

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

The following Commissioner voted “No”: Commissioner Ashbeck

ACTION

3: 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)
- Tracey Lacey, LMFT, Senior Mental Health Services Manager, MHSA Programs, Solano County Department of Health and Social Services
- Cecily Thorton-Stearns, LMFT, Behavioral Health Program Coordinator, San Diego County
- Adrienne Collins Yancey, MPH, Principal Administrative Analyst for the Mental Health Services Act (MHSA), San Diego County
- Flor Yousefian Tehrani, Psy.D., MFT, Program Manager, Orange County Innovation Projects

Tara Niendam, Ph.D., thanked the Commission for taking the time to hear about the Statewide Early Psychosis Innovation Project Collaborative and provided an overview of the project, the goal of which is to bring consumer-level data across a variety of recovery oriented measures to clinicians. Dr. Niendam stated that the meeting packet included an executive summary and additional information to answer the questions from the November meeting. This empowers consumers to make informed care decisions with access to this data. The training and technical assistance collaborative aspect will allow counties and providers to learn from each other. Dr. Niendam highlighted that this project is innovative in that no other state uses this technology and collaborative based approach to harmonize early psychosis programs.

Commissioner Discussion

Commissioner Wooton noticed that all four counties will be using peer specialists with supporting consumers in data collection and wanted to ensure the full involvement of peer specialists in things such as focus groups. Dr. Niendam confirmed that peer and family advocates will be utilized as part of early psychosis program providers and focus groups.

Commissioner Alvarez mentioned that during the presentation it was mentioned that 24 other counties were engaged in similar efforts and asked how the Statewide Collaborative Project is innovative. Dr. Niendam clarified that, while there are 24 other counties with early psychosis programs, none of the programs have an evaluation or an engagement network component as proposed in this project, and it is the hope that these 24 counties will adopt the approach in the near future.

Commissioner Alvarez asked when the evaluation will be generating sufficient data to provide to counties. Dr. Niendam expects that much learning will happen within the first 6 months and will continue throughout the project.

Public Comment

Mark Kormatz expressed hope that this innovation project can be mentioned at an upcoming California Endowment meeting.

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

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

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

The following Commissioners voted "Yes": Commissioners Alvarez, Ashbeck, Danovitch, Wooton, and Vice Chair Aslami-Tamplen

The following Commissioners abstained: Commissioners Madrigal-Weiss, Mitchell, and Chair Boyd

ADJOURN

Chair Boyd thanked everyone for their participation.

There being no further business, the meeting was adjourned at 4:48 p.m.

AGENDA ITEM 2

Action

January 24, 2019 Commission Meeting

San Benito County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Benito County's request to fund the following Innovative project:

(A) Behavioral Health-Diversion and Reentry Court - \$2,264,566

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.

- San Benito County is proposing to establish a mental health court, modeled after its current drug court to better assist Latino persons with serious mental illness with more appropriate services and to reduce recidivism.

Presenters for Calaveras County's Innovation Project:

- Alan Yamamoto, LCSW, Behavioral Health Director
- Don Bradley, San Benito County Sheriff's Department
- Nancy Callahan, Ph.D., I.D.E.A. Consulting

Enclosures (2): (1) Biographies for San Benito County's Innovation Presenters; (2) Behavioral Health-Diversion and Reentry Court Staff Analysis.

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

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

<http://mhsoac.ca.gov/document/2019-01/diversion-and-reentry-court-san-benito-county-innovation-plan>

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

Name:	Behavioral Health-Diversion and Reentry Court
Amount:	\$2,264,566
Project Length:	Five (5) Years



**San Benito County Innovation Plan Presentation:
Behavioral Health-Diversion and Re-entry Court
Presenter Biographies**

Alan Yamamoto, L.C.S.W., Director
San Benito County Behavioral Health Services

Alan Yamamoto, L.C.S.W., has served as the Behavioral Health Director in San Benito County since 2001. Prior to his tenure at San Benito County, Mr. Yamamoto served as the Mental Health Deputy Director for Tehama County for over 10 years. He has also provided consultation services to county and state mental health systems since 1998.

Don Bradley
San Benito County Sheriff Department

Captain Bradly is the Special Project Captain with the San Benito County Sheriff's Department. Captain Bradley was acting Jail Commander from 2015 to 2017 and works closely with San Benito County Behavioral Health to coordinate jail inmate behavioral services. Captain Bradley is also strong advocate for incarcerated veterans and is in full support of this Innovative Project.

Rebecca L. Smith, L.C.S.W.
Veterans Justice Outreach Specialist, VA Palo Alto Health Care System

Rebecca L. Smith has been employed by the Department of Veteran Affairs Palo Alto Health Care System since 2012, where she has served Veterans in various mental health settings. In her current role, she provides advocacy, clinical assessment for and linkage to housing and treatment programs for Veterans in the criminal justice system throughout the counties of Santa Cruz, Monterey, and San Benito. Though not a Veteran herself, her interest in service to this population stemmed from providing caregiver support to an active-duty Marine struggling with the emotional wounds of the war from his duty in Iraq in 2004.

Nancy M. Callahan, Ph.D.
I.D.E.A. Consulting

Nancy M. Callahan, Ph.D., is the owner of I.D.E.A. Consulting, a consulting company based in Davis, California. Over the past 29 years, she has provided exemplary consultation services to state and county Behavioral Health and human service agencies. This includes working with counties to facilitate stakeholder groups, write MHSA Plans, design and evaluate PEI programs, and help plan, design, implement, and evaluate Innovative Plans. Dr. Callahan's organization also supports counties in designing and implementing the delivery of culturally responsive services and writing Cultural Competency Plans.



STAFF ANALYSIS— SAN BENITO COUNTY

Innovation (INN) Project Name:	Behavioral Health-Diversion and Reentry Court
Total INN Funding Requested:	\$2,264,566
Duration of Innovative Project:	Five (5) Years

Review History:

Approved by the County Board of Supervisors:	August 21, 2018
County submitted INN Project:	November 28, 2018
MHSOAC consideration of INN Project:	January 24, 2019

Project Introduction:

San Benito County is proposing to establish a mental health court, modeled after its current drug court to better assist Latino persons with serious mental illness with more appropriate services and to reduce recidivism. The County reports that Hispanics are disproportionately represented in their jails. The jail has capacity to hold 142 inmates, 76% (108) of these inmates are Latino. This number, they report, is not even representative of the percentage of Latinos residing in the County. Further, the County estimates that over 58% of these inmates have an identified mental health need or are “probable” to have a mental health or substance use disorder. (San Benito County INN Plan, page 3)

The County is proposing to develop a “culturally responsive” program, which will work with law enforcement engaged Latinos, in and out of the jail system.

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

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

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

The Need

The County reports two major issues which have created problem with incarceration of Latinos with mental health needs. The current system in the County, where an inmate may receive medical/mental health care while incarcerated is administered by a contracted medical provider, California Forensic Medical Group. The provider, however, does not provide medications (or bridge medications) to the inmate at the time of discharge. If a person is discharged without having made contact with the Behavioral Health Department, and if that discharge is “unplanned” there may be a significant time lag between when (or if) the inmate or their family can re-establish mental health connections and/or services.

In 2016 the County reports that 77.6% of its inmates were Latino. Of those it is believed that 50% either were known to have a mental illness or reported having mental health issues. The County has 142 beds in the jail and so the number of mentally ill incarcerated persons could be as high as up to 55 persons, using the 2016 count. Demographically, the population of the County is comprised of 56% Hispanic., Latinos are represented in the jail system at levels between 71.6%-the highest of 77.6% in 2016, with approximately 50% of these inmates suspected of having or known to have a mental health issue. The County reports that a comparable amount of Latinos and Caucasians (60% and 34%, respectively) participated in behavioral health services.

The County suspects a number of causes for this overrepresentation of Latinos in the jail system: law enforcement disproportionately arresting people who are Latino, there may be a higher representation of Latinos who may be low income and cannot afford higher quality attorney advocacy, the affordability of bail, lack of training in de-escalation by law enforcement when it is called out to resolve a situation, the small size of the county system discharge of inmates at unpredictable times without medications, notifications or coordinated linkage, and a possible loss of or lapse of Medi-Cal eligibility.

Although the County does provide data regarding recidivism based on a 9 year study, those data are representative of the entire United States and are not specific to either San Benito or its Latino population. In order to clarify the need the County proposes to address, an email on 12/26/18 was sent to the county requesting data specific to San Benito County. The county replied that the Sheriff’s department “does not have actual data on the number of people who return to jail, often repeatedly. They also state that they do not have a comprehensive data system, or the capacity or time to go back and

pull out data for our study. However, in a small county, everyone is aware of those persons who are rearrested and booked into the jail multiple times.” **The county may wish to clarify the degree to which recidivism exists locally and specifically if recidivism is more often noted in the Latino population as opposed to any other population in the County.**

The Response

To address this disparity, the County is proposing to develop a mental health court that will provide an opportunity for persons with mental health issues to be offered an opportunity to voluntarily participate in a culturally responsive (page 4) diversion program or an early release program. The program, like the County’s current drug diversion/court program relies on a Judge making a recommendation that a person is eligible to participate in the program and the ongoing collaboration between family, behavioral health staff, law enforcement staff and the individual to meet the various goals set by the group. The individual in the program will make frequent appearances in front of the court to monitor their progress and receive awards and other behavioral reinforcements for positive progress (page 6).

Certainly mental health courts are not new in and of themselves. There are approximately 40 mental health courts in California, two of which (San Francisco and Santa Clara) were part of a four (4) county study as to the effectiveness of mental health courts. Currently research is showing improvements in factors such as recidivism and costs savings, but researchers are not finding any consistency between assessments or programs. As part of its own research, San Benito County visited the program in Santa Clara County, with whom it shares a border. What is unique about San Benito’s proposal is that it is addressing the unique cultural needs of a specific population in a very small community with very limited court resources.

It is exactly this recognition of cultural needs that the Mental Health Oversight and Accountability Commission’s 2017 report on criminal justice and mental health (Together We Can, Reducing Criminal Justice Involvement for People with Mental Illness) emphasized:

Evaluations of collaborative courts have been hampered by design challenges, including the lack of random assignment and adequate comparison groups. Despite these limitations, initial findings suggest that the use of drug courts and mental health courts results in decreased recidivism and re-arrest rates. One study reported less recidivism and improved access to treatment for mental health court participants. *Data on access to collaborative courts for communities of color and transgender people is also limited. Given the lack of access identified in other service sectors, collaborative courts should ensure that communities most affected by disparities are receiving equal access to these diversion programs. Program administrators should take into account feelings of mistrust, especially of governmental programs, by diverse communities as barriers to taking advantage of diversion opportunities through collaborative courts.* (Italics are this writer’s)

Together We Can, page 42

For this Innovation, the County will assemble a team comprised of the Judge, the Public Defender, the District Attorney, a Behavioral Health Case Manager Supervisor, 2 Case Managers (Peer/Family advocate), a Psychiatrist, a County Probation Office and a Superior Court Clerk. Wherever possible new hires will be bi-cultural and bi-lingual. Although the Judge will be responsible for making the determination if a person could be eligible for the mental health court program, there will be two ways in which a person may be identified; through an assessment at booking (jail staff using the Brief Behavioral Health Screening Tool) or at the court hearing where a mental health case manager will do a screening. This case manager will stay with the individual throughout their participation in the program helping with transportation to appointments, including court dates, supportive services to their family, and linkages to other necessary services. (page 10)

Additionally, the jail will send a daily “New Admit Census Log” to Behavioral Health so that they can determine if that person has received services from them before. This also ensures for Behavioral Health staff that the individual does not fall between the cracks. (page 10). Additional services to be provided to the individual include:

- Behavioral Health assessment to identify health, mental health, and substance use needs;
- Participant Journey Mapping
- Development of an Individualized Plan;
- Enrollment in services that help develop skills to reduce mental health symptoms and/or substance use and address health needs;
- Coordination between agencies to ensure access to bridge medications when leaving the jail that are immediately available when the individual is released into the community;
- Attending school or training; learning new skills; gaining employment; developing a supportive network of friends;
- Engaging the families of participants to offer them support and help create a strong supportive system for the individual to succeed; and
- Identification and coordination of safe and stable housing options.
- Coordinate services with the probation department for high-risk persons on probation

The County may wish to describe what training jail staff or law enforcement received or should receive which would help with either eliminating the disproportionate number of Latinos being incarcerated or being identified in the arresting process. Additionally, the County may wish to add a training component to this proposal.

The County may also want to consider working with its partners to develop a pre-discharge policy.

The Community Planning Process

The County reports that the Community Program Planning (CPP) Process for this Innovation occurred as part of the CPP for the Three Year Program and Expenditure Plan conducted from July to December 2018. During that time numerous constituencies were represented (the Behavioral Health Board, Community Correction partners, Veterans Affairs, during a Farmer's Market community mental health day, San Benito County Behavioral Health staff, the community transition center and the county jail staff.). The County reports that meetings were also attended by bi-lingual and bi-cultural staff who could provide translations for monolingual Spanish speakers.

The MHSOAC staff requested data to support the CPP and to determine if the CPP met the criteria established in law. Staff requested number and location of stakeholder meetings as well as feedback from those meetings. While some of these criteria were ultimately addressed in an email, dated 12/26/18 there still remain some questions about where the idea came from, (i.e. did the county develop a services survey?), how stakeholders participated in the development of the budget or what the demographic make-up was of the stakeholders who were involved.

The County may wish to clarify its CPP process.

The Innovation Project was shared with MHSOAC stakeholders on 8/31/18 and no letters of support or opposition were received in response.

Learning Objectives and Evaluation

San Benito County plans on implementing a Behavioral Health-Diversion and Reentry (BH-DRC) program to address the needs of individuals—with particular focus on the Latino Community—that are 18 years of age or older, have been arrested, charged, or convicted of an offense, may have a pattern or substance use, and have been diagnosed with one of the following disorders:

- Major depression
- Bipolar disorder
- Schizophrenia
- Severe mood or anxiety disorder
- Other disorders upon agreement by the BH-DRC Team

It is estimated that 10 individuals will be served annually with a project estimate of 50-individuals over the duration of the project.

The County has developed an evaluation plan that will utilize information gathered from a number of sources to determine whether the program was implemented as planned, and whether or not programmatic and individual outcomes are met. Specifically, the County intends to learn to what extent enrollment in BH-DRC leads to:

- Improved outcomes
- Improved wellness and recovery outcomes for person in jail and/or arrested
- Improved wellness and recovery outcomes for veterans

- Improved collaboration between SBCBH, the Sherriff, courts, and probation
- Improved collaboration between consumers and their families

Additionally, the County will explore the extent to which the program was implemented as planned.

In addition to these learning questions, the County has identified several intended *outcomes* from the project, including increased utilization, reduced mental health symptoms and substance use, improved interagency coordination, among others (**see pgs. 19-20 of County plan**). To determine if outcomes are met, the County will assess a number of *measures*, including:

- Mental health services utilization
- Number of arrests and re-arrests
- Number of days spent in Jail
- Length of time spent in BH-DRC
- Veteran's Services
- Interagency Collaboration Activities Scale, among others (**for complete list of measures, see pgs. 19-20 of County Plan**).

To collect the data necessary for evaluation, the County will track and retrieve information from BH-DRC tracking forms, jail census reports, participant perception surveys, family questionnaires, collaboration surveys, and others. Participant and family Surveys will be administered “at least every 6-months,” and collaborative surveys will be administered “at least annually” (**for complete list of data sources, see pgs. 19-20 of County Plan**). **The County may wish to discuss whether data access and agreements with participating agencies have been established to obtain the necessary information required of the project. Additionally, the County may wish to discuss how baseline data will be established to determine whether or not outcomes were met.**

Overall, San Benito's evaluation plan appears sufficient to examine the extent to which the BH-DRC has an impact on a number of individual and programmatic outcomes. With a lack of culturally-specific diversion programs for those that are criminal justice-involved and suffering from a mental illness, **the County may wish to consider adding a qualitative component to their plan to further explore the process involved in developing such an approach.** The County states that IDEA Consulting will conduct evaluation activities, data analysis, as well as complete the final report. At the conclusion of the project, San Benito County will share findings with various stakeholders to determine how services can be improved or expanded in the future.

The Budget

The County is requesting Innovation funds in the amount of \$2,264,566 for five (5) years. Salary and benefits for 3 County staff in the amount of \$1,106,060 (or 49% of the total project costs) will cover the Team leader/Case Manager Supervisor (at 0.3 FTE), two (2) FTE Case Managers and a 0.1 FTE Psychiatrist.

Additional staffing costs in the amount of \$440,914 (or 19% of the total project cost) will cover the cost of a .05 FTE Probation Office and a 0.5 FTE Court Clerk. These salaries will be paid with Innovation funds through a contract with the Probation Department. Evaluation costs in the amount of \$145,816 represent 6% of the total project costs.

Operating costs, other expenses (i.e. bridge medications) and administrative expenses in the amount of \$572,777 represent 25% of the total project cost.

Salaries and benefits for the Judge, the Public Defender and the District Attorney will be paid through the existing court system.

The County indicates that during the first two years of this plan they will use Innovations reversion funds in the amount of \$766,396.

At the end of five years, if the project is successful, it will be sustained with MHSA funds, county realignment funds and Medi-Cal funding.

Additional Regulatory Requirements

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

References

<http://mhsoac.ca.gov/document/2017-12/criminal-justice-and-mental-health-project-report>

https://www.google.com/search?q=populaiton+of+san+benito+county&rlz=1C1GCEA_e_nUS811US811&oq=populaiton+of+san+benito+county&aqs=chrome..69i57j0l2.5279j0j7&sourceid=chrome&ie=UTF-8

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2019-01/diversion-and-reentry-court-san-benito-county-innovation-plan>

AGENDA ITEM 3

Action

January 24, 2019 Commission Meeting

Calaveras County Innovation Plan

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

(A) **Enhancing the Journey to Wellness: Peer Specialist Program - \$706,366**

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.

- Calaveras County is proposing to hire a Peer Specialist Case Manager to meet with and work with behavioral health consumers upon their discharge from a crisis program (hospitalization). The County asserts that the high rate of recidivism they have experienced following crisis discharge is due to a lack of connecting these consumers to behavioral health supports and would like to test whether or not the Peer Specialist is the critical element to reducing crises recidivism.

Presenters for Calaveras County's Innovation Project:

- Jessica Xiomara Garcia, Director, Learning for Action
- Kristin Brinks, Director, Calaveras Health & Human Services

Enclosures (3): (1) Biographies for Calaveras County’s Innovation Presenters; (2) Enhancing the Journey to Wellness: Peer Specialist Program Staff Analysis; (3) Enhancing the Journey to Wellness: Peer Specialist Program Project Brief.

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

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

<http://mhsoc.ca.gov/document/2019-01/enhancing-journey-wellness-peer-specialist-program-calaveras-county-innovation-plan>

Proposed Motion: The MHSOAC approves Calaveras County’s Innovation Project, as follows:

Name:	Enhancing the Journey to Wellness: Peer Specialist Program
Amount:	\$706,366
Project Length:	Five (5) Years



**Calaveras County Innovation Plan:
Enhancing the Journey to Wellness Peer Specialist Program**
Presenter Biographies

Kristin Brinks, Director

Calaveras County Health and Human Services Agency (HHSA) and Behavioral Health

Kristin has been the HHSA Director since 2016, and previous to this Deputy Director of Community Services for the El Dorado County Health and Human Services Agency.

Jessica Xiomara García, MA, Director

Learning for Action

Jessica has been the third-party evaluator for a variety of Calaveras County Behavioral Health programs since 2012. Jessica drafted the evaluation component for this proposed innovation project.



STAFF ANALYSIS— CALAVERAS COUNTY

Innovation (INN) Project Name:	Enhancing the Journey to Wellness Peer Specialist Program
Total INN Funding Requested	\$706,366
Duration of Innovative Project:	Five (5) Years

Review History:

Approved by the County Board of Supervisors:	September 11, 2018
County submitted INN Project:	November 21, 2018
MHSOAC consideration of INN Project:	January 24, 2019

Project Introduction:

Calaveras County is proposing to hire a Peer Specialist Case Manager to meet with and work with behavioral health consumers upon their discharge from a crisis program (hospitalization). The County asserts that the high rate of recidivism they have experienced following crisis discharge is due to a lack of connecting these consumers to behavioral health supports. The County further believes, and is testing, whether or not the Peer Specialist is the critical element to reducing crises recidivism, since this person will work with the mental health consumer to establish connections to all county services.

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 MHSOAC principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental

health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

The County reports that 39% of clients who are hospitalized experience recidivism and wait too long (up to 6 weeks in some cases) to get connected to community-based mental health services. The County reports that in the last three years 47 unduplicated consumers have had repeated crisis hospitalizations. In the most recent year, 2017-18, 39% of the 104 unduplicated clients who were referred for crisis services were readmitted. The County believes and indicates that research corroborates, that the recidivism rate is linked to the length of time that it takes for a newly discharged patient to get services. Although the standard of care has been that services are provided within a week of discharge, the County reports that its own consumers are not linked to either Full Services Partnership's (FSP) or developing Wellness and Recovery Action Plan's (WRAP) in a timely manner, sometimes taking up to 6 weeks to make the necessary connections. This time gap between discharge and connection to services is well outside the scope of best practice as established by SAMSHA, (within 7 days), and other evidence based practices. The County indicates that some of this lack of connection is due to its being a very rural county (80% of its population lives in unincorporated areas). Additionally, because of its rural-ness, the county reports that incidences of stigma contribute to persons with mental health issues coming in for services.

Upon their discharge and return to the County, consumers' disconnectedness to services may be exacerbated literally, by a lack of a friendly face to help them re-navigate their way into their lives, connecting to services, finding housing, reestablishing themselves socially, economically and geographically. Calaveras County is a very small county with a population of just over 44,000. Because Calaveras is a rural county, over 80% of its population lives in unincorporated areas where services and transportation to and from behavioral health services is extremely limited.

Further complicating the return of consumers to the County and the potential for the high recidivism rate is the catastrophic effect of wildfires that have occurred in the County. In 2015, over 70,000 acres were burned in the County and almost 1000 homes and structures were burned. Due to the resultant housing shortage, rents in the County have risen to approximately \$800 to \$1,000 per month, leaving most low income persons, including those recently discharged from a crisis facility, with few remaining funds to pay for transportation, food, clothing and/or medical care.

The Response

To provide a tangible connection for newly discharged behavioral health patients, the County proposes to hire a Peer Specialist (at the equivalent of a Case Manager II due to the technical nature of the position). This person will convene a Multi-disciplinary team (MDT) to meet with the consumer within 7 days of their discharge to begin to facilitate establishing care for them in all of the domains, including housing. The Peer Specialist will be responsible for convening a team of service providers, including the triage

managers from previously awarded SB 82 triage funds to establish a network of services for the consumer. The primary goal will be to get the consumer into stable housing within one week of discharge. Thereafter, the Peer Specialist will organize and facilitate additional meetings required to connect the consumer with medicine, food, primary health care, transportation and any other specific resources to meet his/her unmet needs. The County acknowledges that this particular Innovation proposal is not about addressing the housing shortage in Calaveras, but it, coupled with the lack of social connectedness, is an almost insurmountable barrier for newly discharged patients.

In addition, the Peer Specialist will provide daily and weekly contacts and support with the targeted consumer after their hospital stay, including home visits and phone check-ins or follow-up. This position will also provide advocacy, navigation support, and maintain a connection through the follow up appointments and referral checks, with a focus on person-centered care and the therapeutic alliance that enables consumers to pursue recovery and life goals across multiple areas—home, school, work, and community. Engagement strategies will be built and sustained on the foundation of hope, mutual trust, respect, effective communication and recognition of the strengths and resources that people experiencing mental illness bring to their recovery. (Taken in part from County proposal, page 7)

The County may wish to discuss plans for the consideration of pre-discharge planning (during hospitalization) or any activities it might consider for the Peer Specialist to engage in with the consumer prior to the discharge.

The Community Program Planning Process

The CPP process for this Innovation Project meets the standards established by WIC 5848(a) in that it includes stakeholders at every developmental stage of the proposal. During both the Annual Update and Three Year Program and Expenditure Plan Community Program Planning (CPP) processes, the County reports that it has repeatedly heard requests for more intensive peer support for case management, housing and post hospitalization support. In the most recent CPP, January through March 2018, including a monolingual focus group facilitated by a bilingual staff person, the County reports that there continue to be concerns about lack of services for consumer driven wellness and recovery strategies, follow up to post hospitalization for mental health consumers, family, input for assessing consumer status after crisis interventions, removing treatment and service barriers associated with the County's remote (and isolated) residents in addition to the lack of housing for low income residents.

The CPP was attended by NAMI, the Mental Health Advisory Board (consumers and behavioral health clients), and representatives of education, law enforcement, veterans and county system of care staff for children and adults. This project was shared with the MHSOAC Stakeholder Contractors on June 19, 2018. The MHSOAC has not received any letters of support or opposition for this proposal.

Learning Objectives and Evaluation

Calaveras County plans on implementing a peer specialist program that seeks to provide case management support to Calaveras County Behavioral Health Services consumers who experience high rates of hospitalization for mental health crises. The County will target individuals of all ages who—over a period of 36 months—have had repeated hospitalizations for a mental health crisis in Calaveras county, and are considered at great risk for relapse. Calaveras County will serve an estimated 40-individuals annually.

The County has developed a thorough evaluation plan that will utilize quantitative and qualitative information to determine whether the program was implemented as planned, and whether or not programmatic and individual outcomes are met. Specifically, the County intends to learn to what extent peer specialist involvement leads to:

- Increased CCBHS mental health services access by consumers that experience repeated hospitalization
- Improved wellness and recovery outcomes
- Contributes to improved collaboration between providers, and between consumers and their providers
- Increased stabilization and/or recovery and wellness for consumers experiencing repeat hospitalization

Additionally, the County intends to learn to what extent the peer specialist program was implemented as planned.

The County has also identified several intended *outcomes* from the project, including increased utilization, decreased hospitalizations, increased family support, increased interagency collaboration, increase in housing stability, among others (**see pgs. 11-12 of County plan**). To determine if outcomes are met, the County will assess a number of *measures*, including:

- mental health services utilization
- number of hospitalizations and emergency room visits
- reports of family support
- stakeholder perception of system-wide collaboration
- number of homeless consumers receiving housing support, among others (**for complete list of measures, see pgs. 11-12 of County Plan**).

The County may wish to consider measuring time from hospitalization to first treatment session as an additional indicator of the effect that peer specialists have on the improved wellness of consumers.

To collect the data necessary for evaluation, the County will track and retrieve information from treatment logs, individual treatment plans, and develop questionnaires that will be administered to participants and their family members, as well as hold interviews with stakeholders and program staff. Questionnaires and interviews will be held at intake, 3-months, 6-months, and 1-year post-implementation of activities (**for complete list of data sources, see pgs. 11-12**). Baseline data will similarly be gathered from wellness surveys, service utilization records, hospitalization records, incarceration rates, and

others in order to examine programmatic effects on consumers, the community, and mental health system.

Overall, Calaveras County's evaluation plan depicts a comprehensive examination of the extent to which the Peer Specialist Program will increase access to mental health services amongst the targeted population. At the conclusion of the project, Calaveras County will share findings with the Health and Human Services Agency, partners, and stakeholders. The County also hopes to share their findings as a potential model for other counties across the state. The final evaluation report will be completed with an internal County Evaluation team.

The Budget

The County estimates that of the total plan costs (\$881,336), it will recoup about \$175,000 in Federal Financial Participation, making the total MHSA Innovation request \$706,336.

The County believes that the Peer Specialist position is so critical to this Innovation proposal that 61% of the total personnel costs, including salary and benefits (\$570,584) are for the Peer Specialist. Additionally, the County will purchase a car for the exclusive use of the Peer Specialist to enable her/him to get around the County, meet with and coordinate services for newly discharged consumers. Vehicle expenses in the amount of \$62,500 represent 8% of the total budget.

Additional budget costs include \$150,000 (21% of the budget) for housing costs related to the Peer Specialist being able to facilitate rents, deposits, etc., on behalf of a consumer and \$86,250 (12% of the budget) for the consultant/evaluator for the project.

Over the course of the five year project, the county anticipates serving 40 clients per year and if the program proves successful in reducing recidivism, will sustain the program with Community Services and Support funds.

Additional Regulatory Requirements

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

References

<https://www.disabilityrightsca.org/system/files/file-attachments/CM6201.pdf>

https://ghpc.gsu.edu/files/2014/01/final_peer_support_report092706.pdf

https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California_Peer_Providers_in_Transition_of_Care_0.pdf

<file:///H:/Management%20Strategies%20to%20Reduce%20Psychiatric%20Readmission%20%20Effective%20Health%20Care%20Program.html>

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2019-01/enhancing-journey-wellness-peer-specialist-program-calaveras-county-innovation-plan>



ENHANCING THE JOURNEY TO WELLNESS PEER SPECIALIST PROGRAM

SUMMARY OF INNOVATION PROJECT:

This MHS Innovation Plan provides Peer Specialist case management support to targeted mental health clients in Calaveras County who experience high rates of hospitalization for mental health crisis. The goal of this project is to increase the timely connection of these mentally ill clients to existing mental health services in Calaveras County, and provide housing supports, with the intention to reduce the need for repeated mental health crisis hospitalizations and help consumers on the road to recovery and wellness.

We know from the literature that recurrent psychiatric hospitalizations and emergency department utilization is common among those with serious mental illnesses and others with behavioral health conditions (HSS and Westat, 2015). The result is excessively high healthcare costs, and in some cases preventable overuse of services. Furthermore, people with serious mental illness die, on average, twenty-five years earlier than those in the population without a serious mental illness. This disparity is largely due to treatable medical conditions that remain unaddressed due to factors at the client, treatment, provider, clinic, and system levels of health and mental health service delivery (Brekke, J. S. et al., 2013).

Further complicating connecting patients to services is the fact that Calaveras County is a remote rural community located in the foothills of the Sierra Nevada mountains. Eighty percent of the county's population of 44,515 lives in unincorporated areas, where public transit is minimal at best. Our rural location and culture increases potential for stigma and delay in seeking mental health services. High rates of recurring hospitalization for residents with mental health issues have been a longstanding challenge in the county. The geographic and transportation barriers, along with lack of affordable stable housing, are likely key contributing factors to those in need not accessing services or high attrition rates following hospitalization.

The primary purpose of this project is to increase timely access of mental health services – which is a great need in our county. HHS/BHS wants to learn if quality peer supports offered immediately after a hospitalization, within 7 days – a widely accepted quality of care indicator – helps to reduce readmissions of persons with multiple hospitalizations in Calaveras County for all age groups and if this new project can help to create an efficient, effective structure for the proposed small rural county comprehensive peer navigation crisis stabilization model.

The newly hired CCBHS Peer Specialist Case Manager will be an integral component of the program and will provide immediate help and support to clients after a mental health crisis hospitalization, assist them with housing supports if needed immediately using the Housing First best practice strategy, and effectively coordinate, communicate, and collaborate services with additional providers. While working in conjunction with professional therapists, social workers, and psychiatrists, the Peer Specialist Case Manager will focus on empathy and empowerment that inspires recovery through modeling recovery, sharing skills and education, assisting in navigating the local system of care and services, as well as providing housing support resources. The CCBHS Case Manager Peer Specialist will use their personal experience with recovery from mental health disorders to support others in recovery and wellness after a mental health crisis hospitalization. Currently, homeless or at risk of homelessness consumers returning from a hospital stay are not offered housing supports until assessed for case management services through Full Service Partnership (FSP) Program (and this can take up to a month once assessed

for FSP supports). This delay can create difficulty for BHS direct service staff in locating the consumer to offer services. The Case Manager will also work with consumers to develop a WRAP plan.

In addition, CCBHS Peer Specialist Case Manager support will overcome some of the geographic barriers existing in Calaveras County by offering support where the client is (through home visits) rather than asking for the patient to keep an appointment at a centralized location. Transportation support will also be offered by the Peer Specialist Case Manager to mental health and community services when needed. Connections with the family as well as introduction to supporting community groups or services will be part of the Peer Specialist Case Manager responsibilities to address the problems surrounding geographic and social isolation.

Calaveras County, a small, rural county would implement a new peer specialist support for the most vulnerable clients. We believe a peer specialist intervention will help increase access to timely services by providing quick intervention, within 7 days – an innovation for our county. We will test this approach to increasing quality and coordination of services in a way that is innovative for our county and we will add to the body of information currently missing for other small counties as well as contribute to UCSF research.

BUDGET:

The estimated project cost for a full 5-year period is \$706,336, using MHS Innovation funds. Over 60% of the proposed budget is allocated to cover personnel cost, specifically, resourcing the Peer Specialist position in addition to supporting transportation, connection to housing, and adequate resources for evaluation and learning. The level of budget allocation to ensure this position is well resourced demonstrates just how much Calaveras County believes the innovative approach of the Peer Specialist will lead to impactful outcomes for clients, increased access to mental health services, and greater coordination of care. The County is committed to removing barriers that peer specialists and clients face to ensure the project is set up for success.

If the program is effective and is sustainable through other available funding, CHHSA/BHS may implement the service ongoing through another MHS funding component after the five-year project ends.

ADDRESS ANY AREAS INDICATED IN MHSOAC STAFF SUMMARY:

The Peer Specialist will work closely with the discharge planner prior to discharge so that the consumer and peer will have an initial meeting within 7 days following discharge. By being involved in discharge planning, the Peer will have an opportunity to start building a trusting relationship with the consumer and become well-versed in their needs.

To track when the Peer makes first contact after discharge and track connection to services the consumer receives, we will include time from hospitalization to first treatment session as an indicator in our evaluation plan.

AGENDA ITEM 4

Information

January 24, 2019 Commission Meeting

Overview of Governor's Proposed Budget for Fiscal Year 2019-20

Summary: The Commission will be presented with an overview of the Governor's proposed budget for fiscal year 2019-20 and its impact on the community mental health system.

Presenters:

- Teresa Calvert, Assistant Program Budget Manager, Department of Finance
- Anam Khan, Health & Human Services Unit, Department of Finance

Enclosure (1): MHSOAC Financial Oversight Report, January 2019

Handout: None



Financial Report
January 24, 2019



**Mental Health Services
Oversight & Accountability Commission**

Key Findings:

- A. MHSA revenue distributed to the Counties in Fiscal Year 2018/19 is 15.9 percent behind the FY 2017/18 pace through January.

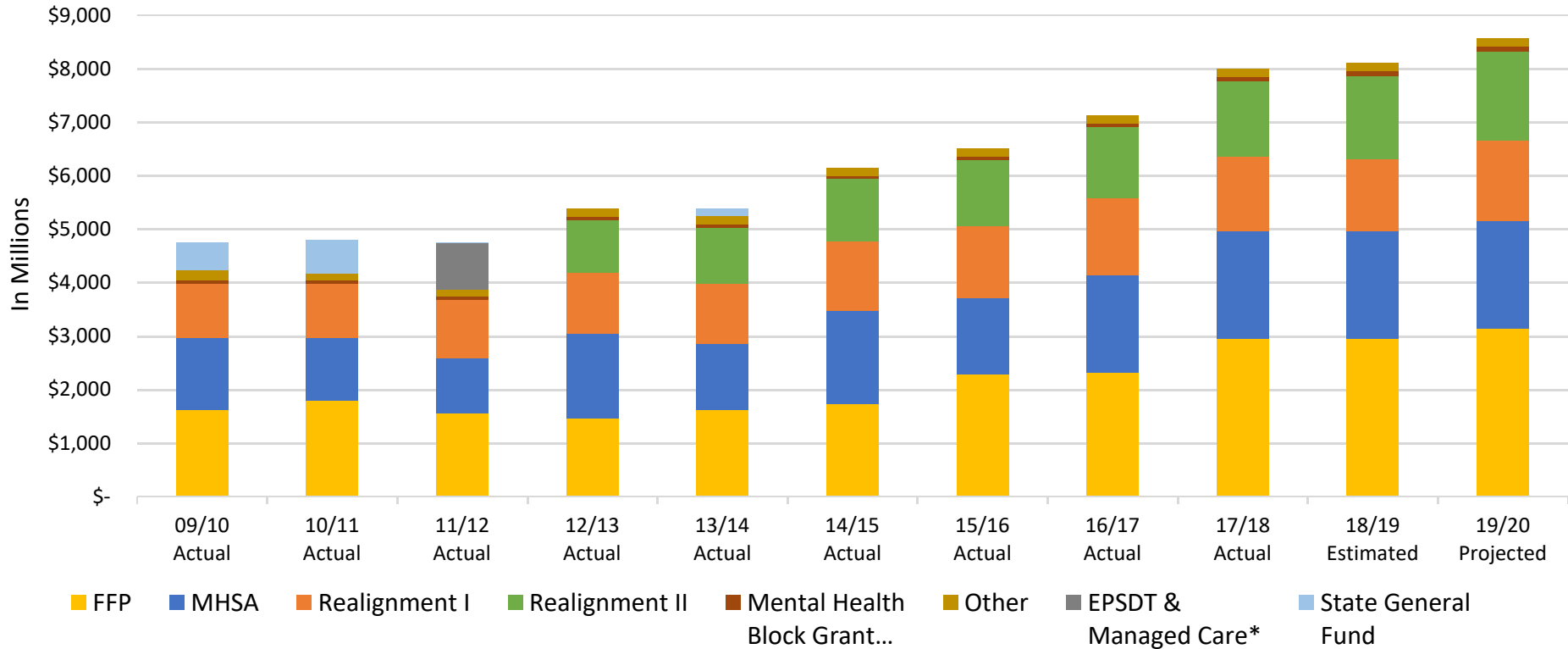
- B. DHCS estimates Federal Financial Participation reimbursements to the Counties for Specialty Mental Health Services will grow 0.2 percent in FY2018/19 over FY2017/18, and projects further growth of 6.4 percent in FY 2019/20.

- C. The Governor's FY 2019/20 January Proposed Budget includes a projected reserve in the Mental Health Services Fund for FY 2019/20 of \$1,086.12 million, which is 13.3 percent higher than estimated reserve for FY 2018/19 (\$958.64 million).

Mental Health Funding at the Local Level

FY 09/10 - 19/20

The graph below displays local mental health funding levels from FY 2009/10 to 2019/20 from different funding sources. Projected funding to the counties in FY 2019/20 is 80.3 percent higher than in FY 2009/10 and 7.04 percent higher than FY 2017/18.



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

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

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

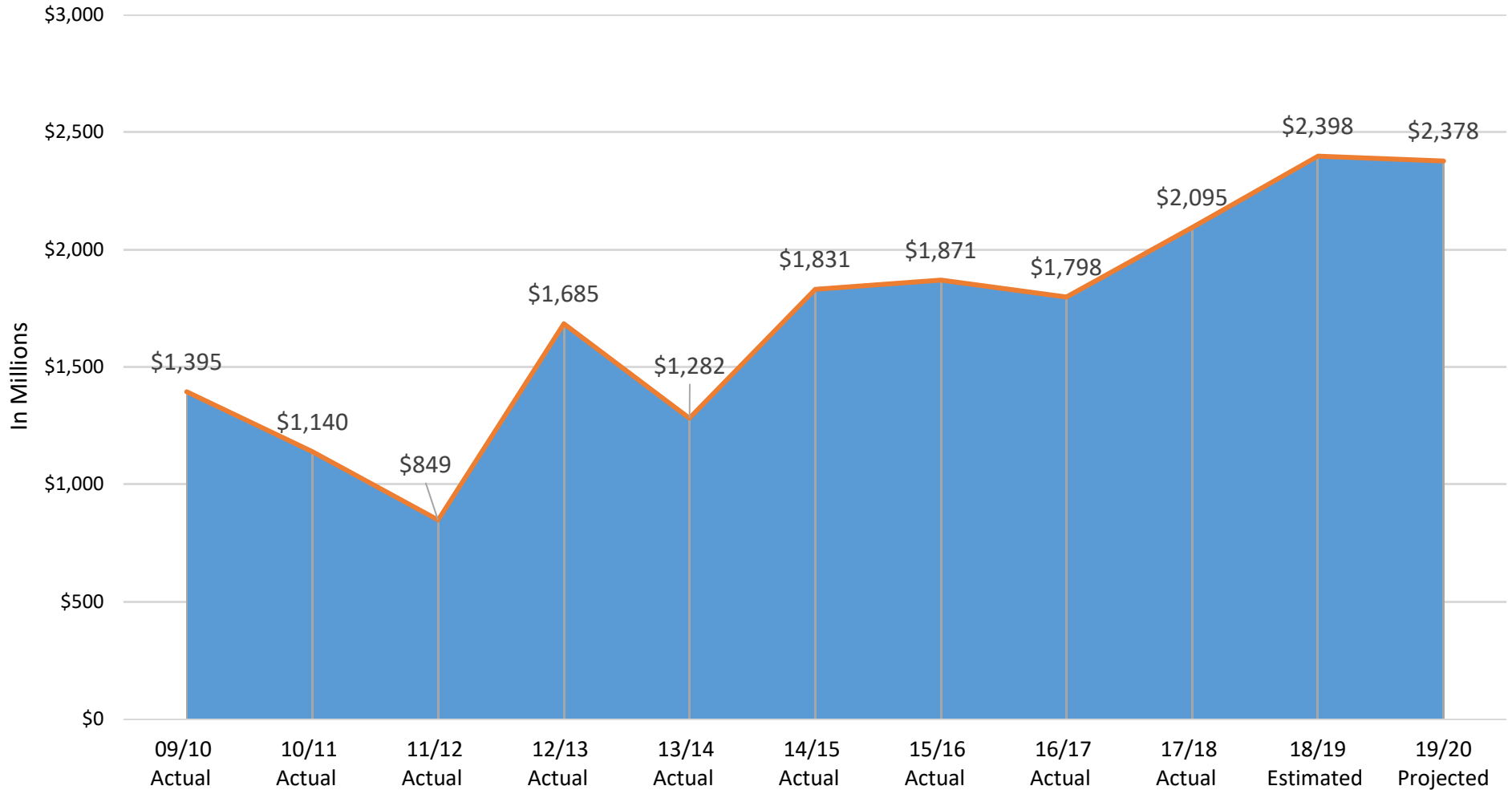
* One time redirected MHSA funding for EPSDT and Mental Health Managed Care. State General Fund amounts for Mental Health were replaced by Realignment I and Realignment II.

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

Total MHSA Revenue

FY 09/10 - 19/20

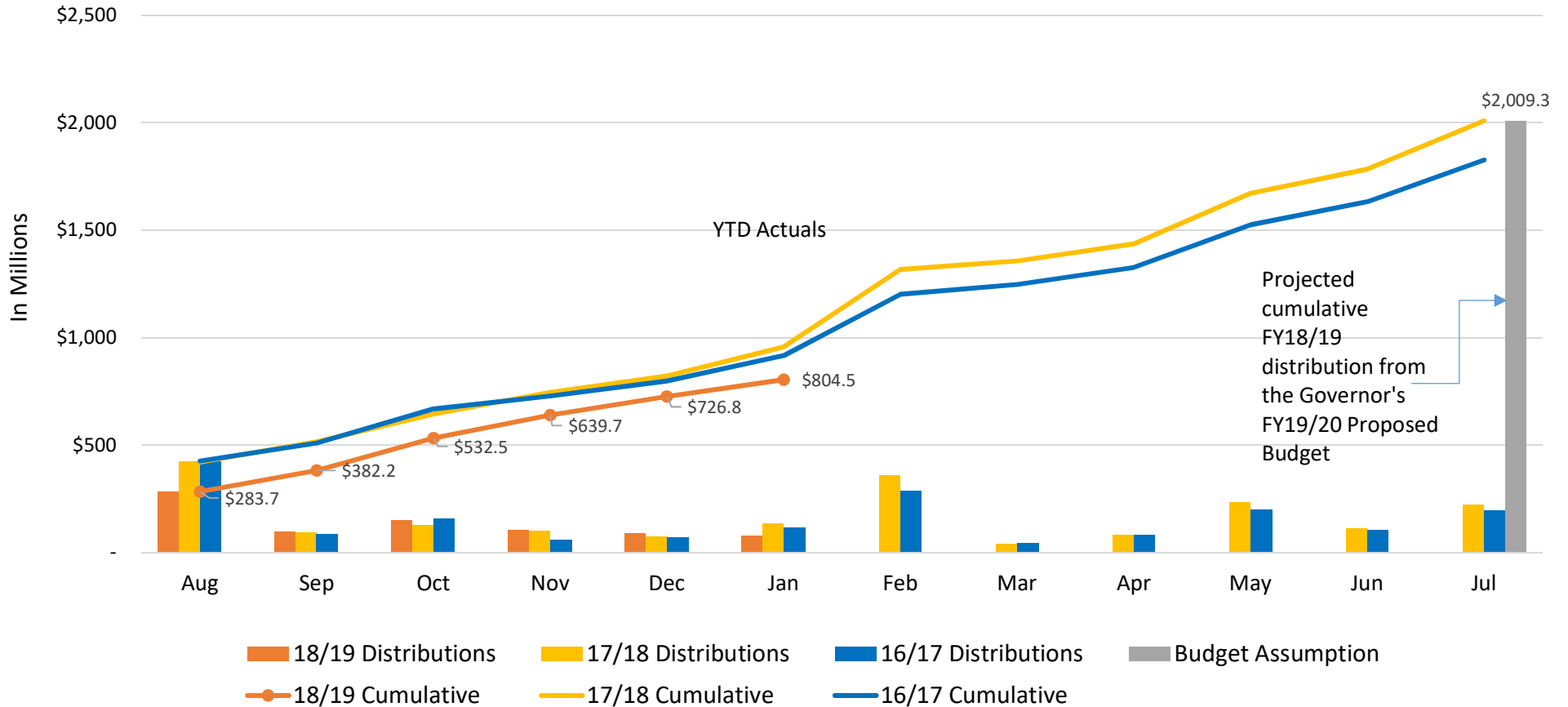
The graph below indicates the actual and estimated total MHSA Revenues deposited to the fund from FY 2009/10 to 2019/20. MHSA funding is susceptible to economic fluctuations as noted in the graph below. Each county is required to maintain a Prudent Reserve that is designed to preserve current levels of services in years with extreme decreases in revenue. Additionally, the State maintains a reserve for economic uncertainties in each special fund. The Governor's FY 2019/20 January Proposed Budget includes a projected reserve in the Mental Health Services Fund for FY 2019/20 of \$1,086.12 million, which is 13.3 percent higher than estimated reserve for FY 2018/19 (\$958.64 million).



Mental Health Services Funds Distributed to Counties

FY 2018/19

This chart reflects changes to distributions to the counties of MHA Funds from August 2018 to Jan 2019. Funds are distributed to the counties in monthly lump sums and attributed in county accounts to Community Services and Supports, Prevention and Early Intervention, and Innovation. The distribution in FY 2018/2019 represents actual Mental Health Services funds distributed for the first 6 months of the fiscal year. Also shown are monthly and cumulative distributions for FY2016/17 and FY2017/18 and the projected cumulative distribution for FY18/19 included in the Governor's Proposed Budget for FY19/20.

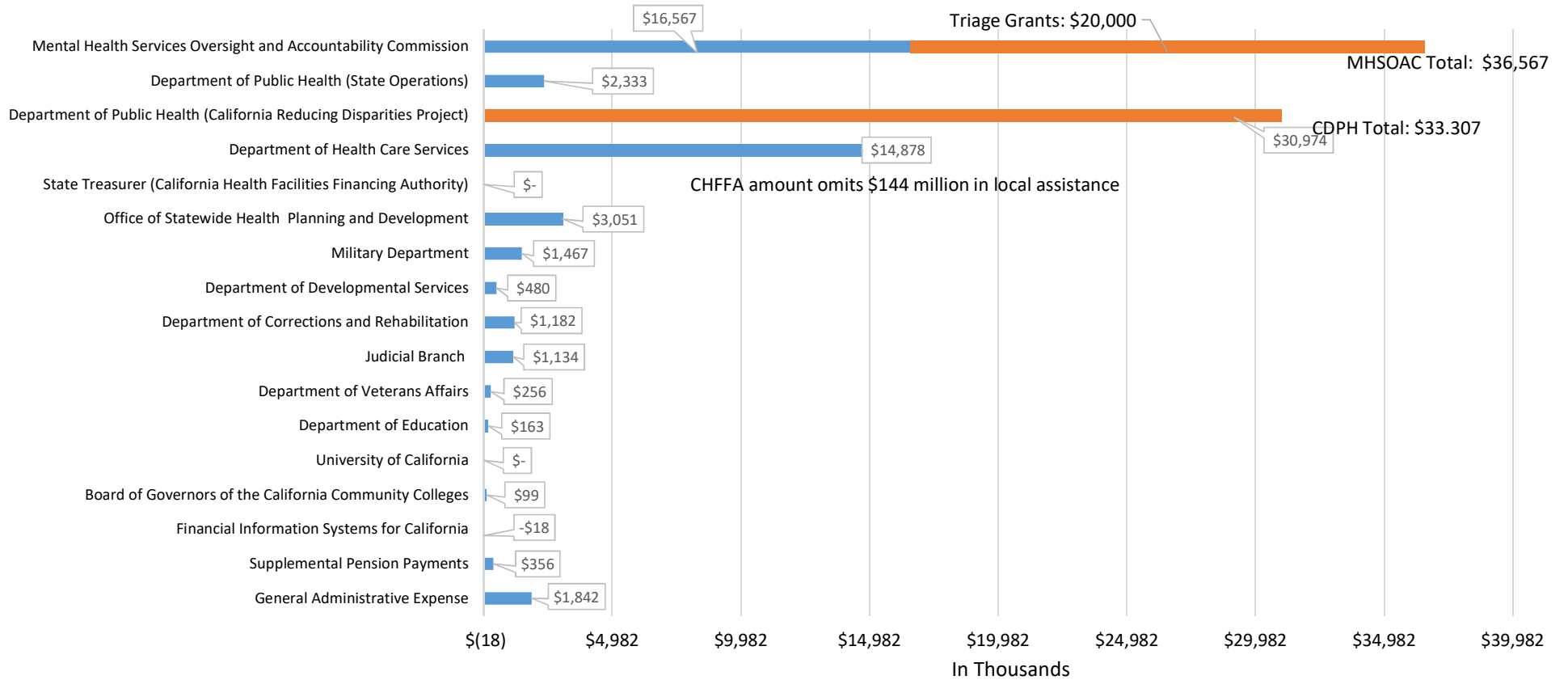


For a year to date, county by county summary of distributions, refer to the following link:
https://www.sco.ca.gov/Files-ARD-Payments/mentalhealthservices_ytd_1819.pdf

MHSA Administration Funds by Department (In Thousands)

FY 2019/20

This figure identifies the state entities that receive MHSA Administrative Funds. These funds are utilized for administration, services, research, etc. A portion of these funds were reappropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year than which they are expended. Zero amounts are shown for CHFFA (\$16,453,000 in 2018/19) and University of California (\$961,000 in 2018/19). There is a reimbursement from FISCAL in the amount of \$18,000. General Administrative Expense is now a general line item in the budget for each fund rather than line items in individual departmental budgets.



Appendix 1: Mental Health Funding Levels at the Local Level (In Millions) FY 09/10 - 19/20

	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Actual	17/18 Actual	18/19 Estimated	19/20 Projected
State General Fund	\$ 518.0	\$ 619.4	\$ 0.1	\$ -	\$ 142.5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Realignment I	\$ 1,023.0	\$ 1,023.0	\$ 1,097.6	\$ 1,131.3	\$ 1,129.6	\$ 1,303.3	\$ 1,349.3	\$ 1,435.4	\$ 1,396.6	\$ 1,351.9	\$ 1,501.1
Realignment II	\$ -	\$ -	\$ -	\$ 987.3	\$ 1,047.4	\$ 1,163.3	\$ 1,230.3	\$ 1,328.6	\$ 1,415.4	\$ 1,542.1	\$ 1,658.0
Mental Health Block Grant (SAMHSA)	\$ 54.0	\$ 53.7	\$ 53.1	\$ 57.4	\$ 57.4	\$ 62.2	\$ 63.1	\$ 69.2	\$ 74.2	\$ 95.2	\$ 95.2
FFP	\$ 1,619.2	\$ 1,799.9	\$ 1,562.5	\$ 1,465.0	\$ 1,624.0	\$ 1,743.0	\$ 2,293.5	\$ 2,319.6	\$ 2,954.1	\$ 2,960.3	\$ 3,149.4
MHSA	\$ 1,347.0	\$ 1,165.1	\$ 1,029.9	\$ 1,589.0	\$ 1,235.0	\$ 1,730.1	\$ 1,418.8	\$ 1,827.0	\$ 2,009.3	\$ 2,009.3	\$ 2,009.3
EPSDT & Managed Care*	\$ -	\$ -	\$ 861.2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ 187.6	\$ 139.4	\$ 139.4	\$ 150.0	\$ 150.0	\$ 150.0	\$ 150.0	\$ 150.0	\$ 150.0	\$ 150.0	\$ 150.0
TOTAL	\$ 4,748.8	\$ 4,800.5	\$ 4,743.8	\$ 5,380.0	\$ 5,385.9	\$ 6,151.8	\$ 6,504.9	\$ 7,129.8	\$ 7,999.6	\$ 8,108.8	\$ 8,563.0

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

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

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

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

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

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

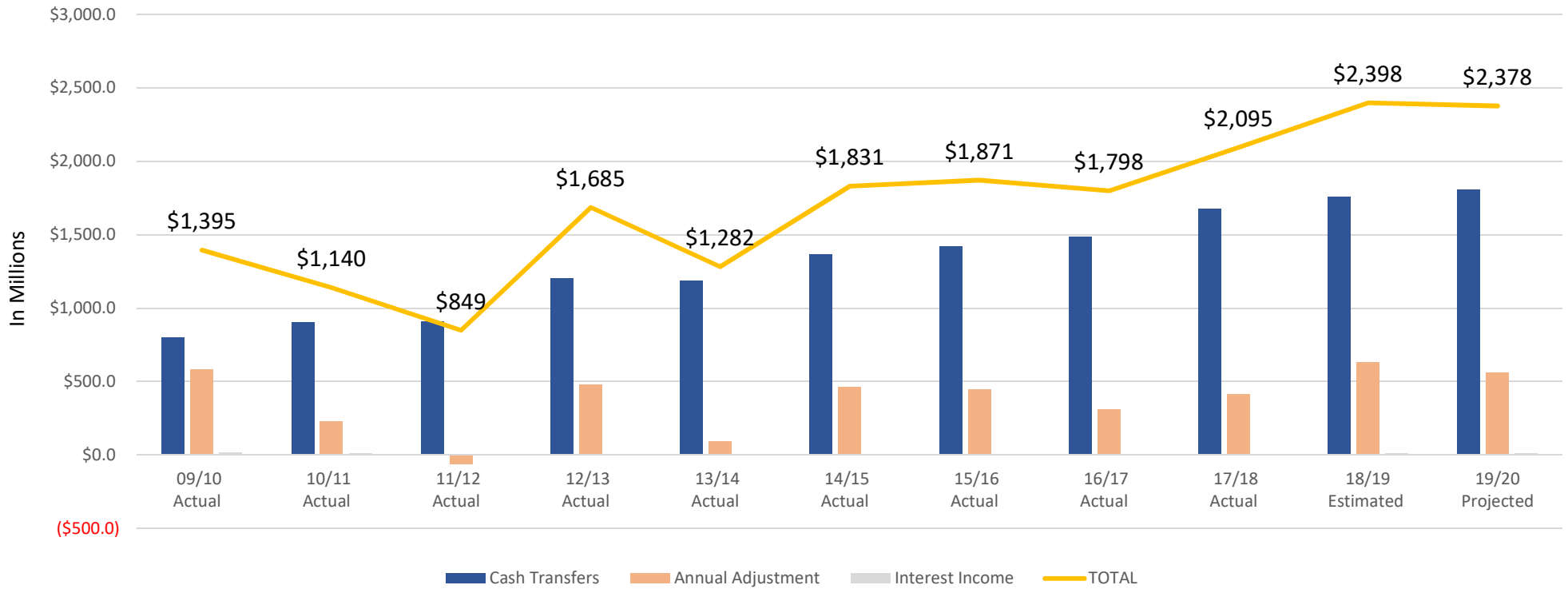
Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive Realignment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

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

Appendix 2: Total MHSR Revenue

FY 09/10 - 19/20

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



	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Actual	17/18 Actual	18/19 Estimated	19/20 Projected
Cash Transfers	\$799.0	\$905.0	\$910.0	\$1,204.4	\$1,187.4	\$1,366.5	\$1,423.5	\$1,484.1	\$1,675.45	\$1,756.79	\$1,808.2
Annual Adjustment	\$581.0	\$225.0	(\$64.0)	\$479.8	\$94.3	\$464.1	\$446.0	\$311.7	\$414.0	\$632.0	\$560.0
Interest Income	\$14.9	\$9.7	\$2.7	\$0.7	\$0.5	\$0.8	\$1.2	\$2.6	\$5.3	\$9.4	\$9.4
TOTAL	\$1,394.9	\$1,139.7	\$848.7	\$1,684.9	\$1,282.2	\$1,831.5	\$1,870.8	\$1,798.3	\$2,094.8	\$2,398.1	\$2,377.6

AGENDA ITEM 5

Information

January 24, 2019 Commission Meeting

Executive Director Report Out

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

Presenter: Toby Ewing, Executive Director

Enclosures (7): (1) The Motions Summary from the December 18, 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 (7) Strategic Planning Update

Handouts: None.



Motions Summary
Commission Meeting
December 17, 2018

Motion #: 1

Date: December 17, 2018

Time: 4:08 PM

Motion:

The Commission approves the October 25, 2018 meeting minutes, and approves the September 27, 2018 meeting minutes with the following amendments: (a) Page 11, delete, “and left the room pursuant to Commission policy”; (b) Page 12, delete, “Commissioners Brown and Wooton rejoined the Commissioners at the dais.”; (c) Page 18, delete, “and left the room pursuant to Commission policy.”; and (d) Page 18, delete, “Commissioner Brown rejoined the Commissioners at the dais.”

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Ashbeck

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Chair Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>



Motion #: 2

Date: December 17, 2018

Time: 4:34 PM

Motion:

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

Commissioner making motion: Commissioner Alvarez

Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 3

Date: December 17, 2018

Time: 4:46 PM

Motion: 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

Commissioner making motion: Commissioner Ashbeck

Commissioner seconding motion: Commissioner Wooton

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Commissioner Mitchell	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Chair Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Summary of Updates

Contracts

New contract [18MHSOAC020](#)

Contract [16MHSOAC021](#) is complete

Contract [17MHSOAC024](#) was extended for 6 months

Total Contracts: 5 (4 Active)

Funds Spent Since November Commission Meeting

16MHSOAC021	\$150,000
17MHSOAC024	\$25,125
17MHSOAC081	\$160,000
17MHSOAC085	\$0
18MHSOAC020	\$261,443
Total	\$596,568

Contracts with Deliverable Changes

[16MHSOAC021](#)

[17MHSOAC024](#)

[17MHSOAC081](#)

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	\$1,000,000

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	Complete	Yes
Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	07/28/18	Complete	No

MHSOAC Evaluation Dashboard Month September 2018
 (Updated September 6th, 2018)



The iFish Group: Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff	Rachel Heffley
Active Dates	12/28/17 - 6/30/19
Total Contract Amount	\$423,923
Total Spent	\$311,968

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	06/30/19	Yes

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff	Michelle Adams
Active Dates	7/1/2018-7/31/2020
Total Contract Amount	\$1,200,000
Total Spent	\$260,000

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	09/30/18	Yes
Survey Development Methodology/Survey	Complete	12/31/18	Yes
Survey Data Collection/Results/Analysis of Survey	In Progress	3/30/20	Yes
Summary Report (3 Public Engagements)	Not Started	3/30/19	Yes
Summary Report (3 Public Engagements)	Not Started	6/30/19	Yes

MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

Outcomes Reporting Draft Report —3 Sections	Not Started	9/31/19	Yes
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	Yes
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

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff	Rachel Heffley
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 four-county sample (Amador, Fresno, Orange, & Ventura) 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

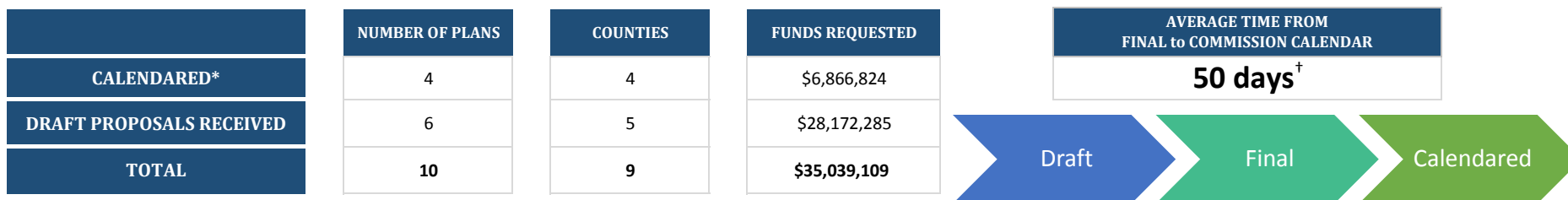
The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff	Rachel Heffley
Active Dates	01/01/19 - 12/31/19
Total Contract Amount	\$306,443
Total Spent	\$261,443

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	01/01/19	No
Data Management Support Services	Not Started	12/31/19	No

INNOVATION DASHBOARD - JANUARY 2019 (Current)

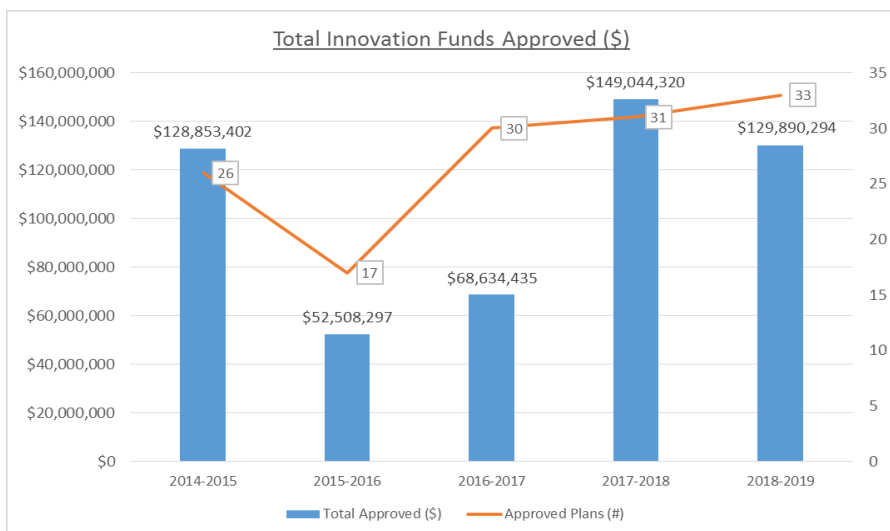


* **January:** Calaveras (1), San Francisco (1), San Benito (1)

February: Nevada (1)

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

Previous FY Trends:



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

† Number of counties that have NOT presented an INN Plan to the Commission since 2013: 5 (8%)

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19 (to date)
APPROVED INN Funds:	\$127,742,348	\$46,920,919	\$66,625,827	\$143,871,714	\$126,493,040
APPROVED Ext. Funds:	\$1,111,054	\$5,587,378	\$2,008,608	\$5,172,606	\$3,397,254
Plans Received:	N/A	N/A	33	34	33
Plans APPROVED:	26	17	30 (91%)	31 (91%)	33 (100%)
Participating Counties:	16	15	18 (31%)	19 (32%)	22 (37%)
Participating Counties APPROVED:	N/A	N/A	17 (94%)	16 (84%)	22 (100%)

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	Calaveras	Enhancing the Journey to Wellness Peer Specialist Program	\$706,366.00	5 Years	6/6/2018	9/17/2018	JANUARY
CALENDARED	San Francisco	FUERTE	\$1,500,000.00	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	Nevada	Homeless Outreach and Medical Engagement (HOME) Team	\$2,395,892.02	5 Years	11/6/2018	12/19/2018	FEBRUARY

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	(PENDING)	(PENDING)
DRAFT	San Bernardino	Innovative Remote Onsite Assistance Delivery-InnROADS	\$17,024,309	5 Years	10/23/2018	(PENDING)	(PENDING)
DRAFT	Mono	Eastern Sierra Learning Collaborative: A County Driven Regional Partnership	\$84,935	2 Years 9 Months	11/19/2018	(PENDING)	(PENDING)
DRAFT	Imperial	Positive Engagement Team (PET)	\$3,121,604	5 Years	10/9/2018	(PENDING)	(PENDING)
DRAFT	Alameda	Supportive Housing Community Land Trust (CLT)	\$5,000,000	5 Years	11/2/2018	(PENDING)	(PENDING)
DRAFT	Imperial	Link Crew Collaborative	\$2,538,018	5 Years	11/8/2018	(PENDING)	(PENDING)

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

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.

Calendar of Commission Meeting Draft Agenda Items

Proposed 01/11/19

All agenda items and meeting locations are subject to change

February 28: Sacramento, MHSOAC

- **Stakeholder Activity and State of the Community Reports**
The Commission will hear a presentation on the activities of the seven stakeholders and a review of the State of the Community reports; a required contract deliverable outlining the work done on behalf of the specific populations.
- **Innovation Project: Nevada County**
Homeless Outreach Services Team (HOST)
- **Innovation Projects: Imperial County (2)**
Positive Engagement Team (PET) and Link Crew Collaborative
- **Legislative Priorities**
The Commission will consider legislative priorities for the 2019 legislative session.
- **Strategic Planning Session**
The Commission will continue the facilitated strategic planning discussion about the role of the Commission, and the goals and objectives of the Strategic Plan which will be developed through the strategic planning process led by Susan Brutschy, President of Applied Survey Research.

March 28: Sacramento, MHSOAC

- **Innovation Projects**
The Commission will consider approval of county Innovation plans.
- **Legislative Priorities**
The Commission will consider legislative priorities for the 2019 legislative session.
- **Use of County Innovation Funds**
The Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.
- **Strategic Planning Session**
The Commission will continue the facilitated strategic planning discussion about the role of the Commission, and the goals and objectives of the Strategic Plan which will be developed through the strategic planning process led by Susan Brutschy, President of Applied Survey Research.

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.
- **Innovation Projects**
The Commission will consider approval of county Innovation plans.
- **Transition Age Youth RFP Outline**
The Commission will consider approval of an outline for a Transition Age Youth RFP.
- **Senate Bill 1004 Prevention and Early Intervention Project**
The Commission will hear details of the SB1004 and PEI project plan.

May 23: TBD

- **Innovation Projects**
The Commission will consider approval of county Innovation plans.
- **Governor's May Budget Revise Update**
The Commission will be presented with information regarding the impact of the Governor's May Revision on the Mental Health Services Act and community mental health.
- **Workplace Mental Health**
The Commission will be presented with the first read of the Workplace Mental Health Strategic Plan.

June: No Meeting

July 25: TBD

- **Suicide Prevention Strategic Plan**
The Commission will be presented with the first read of the statewide Suicide Prevention Strategic Plan.

August 22: TBD

- **School Mental Health Policy Project**
The Commission will be presented with the first read of the School Mental Health Policy Project findings.

Agenda Item 5, Enclosure 6: DHCS Status Chart of County RERs Received
January 24, 2019 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 January 24th, 2019.

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.

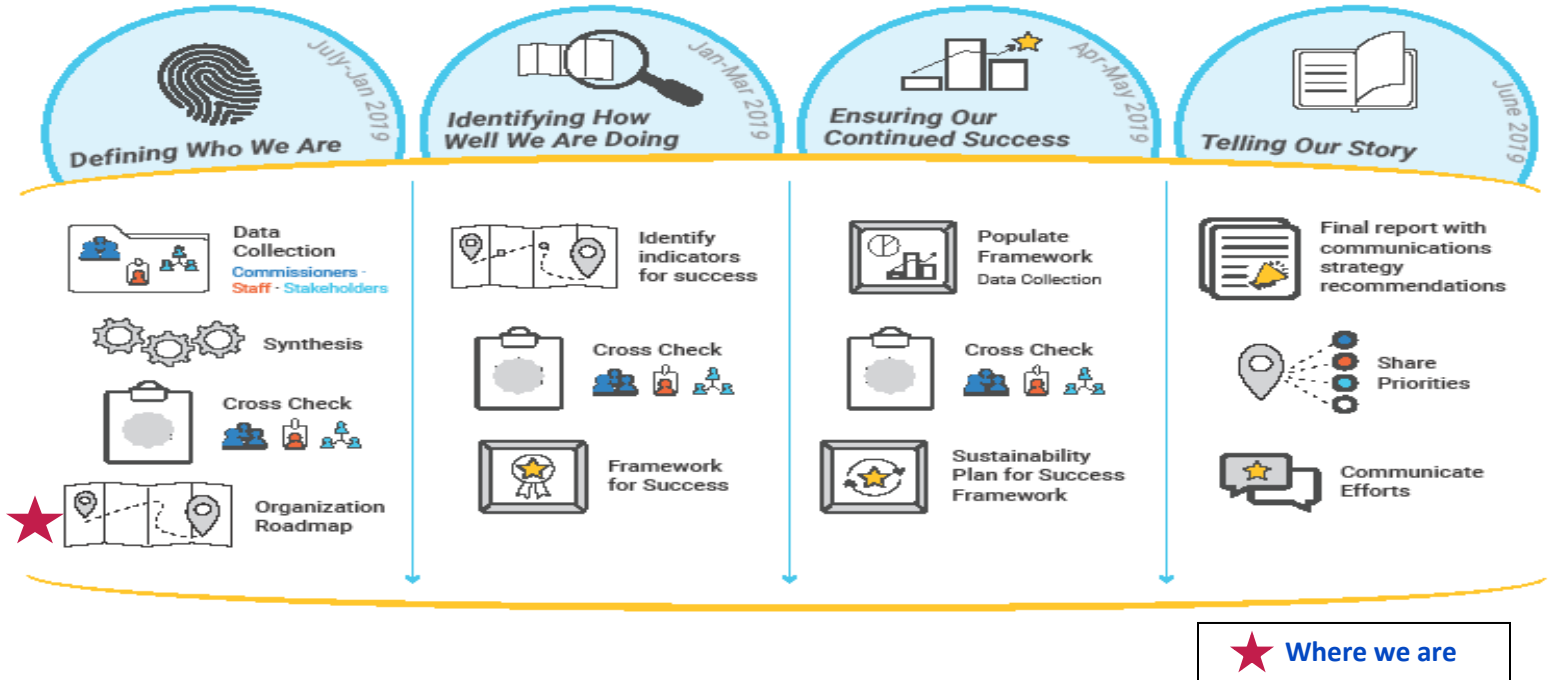
The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at <http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx>. 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](http://www.dhcs.ca.gov/services/MH/Pages/Annual%20MHSA%20Revenue%20and%20Expenditure%20Reports%20by%20County%20FY%2016-17.aspx). County RERs for reporting year FY 2017-18 are not yet accessible through the Department's website.

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> for Reporting Years FY 2012-13 through FY 2016-17 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](http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA%20Reversion%20Funds%20Report.pdf)

Strategic Plan Process Map Summary



Activities in November and December 2018

Throughout November and December, ASR continued to work closely with the Commission’s project design team to continue moving forward with the results based strategic planning efforts. The Commission meeting held on November 15, 2018 generated valuable feedback and learnings, in terms of how the Commissioners view their role in transforming the mental health system for the state of California as well as initial thoughts about where the opportunities lie in order to achieve transformation. This meeting served as a second opportunity for members of the public to work with Commissioners and discuss their thoughts and opinions and provide feedback about the strategic planning process. In addition, a working version of the Commission’s organizational roadmap was shared, with an opportunity for the Commissioners to provide preliminary feedback for ASR. We are continuing to revise this working document as we gather more information and generate high level takeaways from these meetings.

Next Steps

In January 2019, ASR attended a Commission staff meeting to include staff members in the strategic planning process, provide updates, and gather preliminary feedback on the organizational roadmap. The ASR team is continuing to work with staff to facilitate and obtain feedback and input. Throughout the rest of January, ASR will continue to revise the working organizational roadmap in preparation of bringing it back to the Commission. The process will move into identifying indicators for success while cross checking with Commissioner’s, staff, and the public in the early spring. Ultimately, the ASR team will present a draft results framework to the Commission at a regular Commission meeting with opportunity for public comment and feedback in late spring.

If you have any questions, please email ASR President, Susan Brutschy, at susan@appliedsurveyresearch.org.

AGENDA ITEM 06

Action

January 24, 2019 Commission Meeting

San Francisco County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Francisco County's request to fund a new Innovative project:

(A) ***Fuerte School-Based Prevention Groups - \$1,500,000***

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

- The Fuerte program is proposed as an adaptation of a promising school-based prevention approach to promote support around acculturation and behavioral health access for immigrant youth, ages 12 to 18, in the San Francisco Unified School District. By introducing this adaptation into the mental health system of California, San Francisco County hopes to reduce behavioral health disparities among newcomer youth and create a "playbook" that other counties can use to adopt and implement the groups for other immigrant populations. The "playbook" will be developed using a mixed-methods approach as part of a comprehensive evaluation.

San Francisco County will accomplish the goals of the Fuerte program through an ongoing collaboration between the San Francisco Unified School District, the San Francisco Department of Public Health, and the Departments of Psychiatry and Pediatrics at the University of California, San Francisco.

Presenters for San Francisco County's Innovation Project:

- Farahnaz Farahmand, Ph.D., Assistant Director at San Francisco Department of Public Health, Behavioral Health Services, Children, Youth, & Families System of Care
- William Martinez, Ph.D., Assistant Professor in the Department of Psychiatry at the University of California, San Francisco and Director of the Child and Adolescent Services clinic in the Division of Infant, Child, and Adolescent Psychiatry at Zuckerberg San Francisco General Hospital
- Angelina Romano, MSW/PPS, School social worker and District Coordinator for San Francisco Unified School District's Refugee and Immigrant Supports in Education

Enclosures (3): (1) Biographies for San Francisco County Innovation Presenters, (2) Staff Analysis, and (3) Letter of Support received from California Pan-Ethnic Health Network (CPEHN) via email

(County did not submit the optional brief)

Handouts (1): (1) PowerPoint Presentation

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

<http://mhsoac.ca.gov/document/2019-01/fuerte-school-based-prevention-groups-san-francisco-county-innovation-plan>

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

Name: *Fuerte* School-Based Prevention Groups

Amount: \$1,500,000

Project Length: Five (5) Years



**Biographies for San Francisco County Innovation Project:
*Fuerte School-Based Prevention Groups***

Farahnaz Farahmand, Ph.D., is an Assistant Director at San Francisco Department of Public Health (SFDPH), Behavioral Health Services (BHS), Children, Youth, & Families System of Care (CYFSOC). She completed her APA-accredited doctoral training in Clinical Child Psychology through Chicago's DePaul University, and her Doctoral Internship and Postdoctoral Fellowship at the APA-accredited UCSF/ZSFGH, Child & Adolescent Services. Dr. Farahmand oversees various practice improvement and system change efforts for CYFSOC. Her background includes providing hospital-, school-, and community-based mental health services to children, youth, and families in under-resourced urban communities and delivering services through a strength-based, multi-cultural, and trauma-informed lens. She is aware of the larger social forces (e.g., racism, discrimination, institutionalized oppression) that have contributed to inequality for many groups and has discovered how these conditions influence access and engagement in behavioral health services. In addition, while she is dedicated to providing evidence-based services, she is also aware most empirically-supported treatments are not developed and/or evaluated with the largely non-White, low-income, and highly stressed families SFDPH is committed to serving. Subsequently, she has a strong background in research and has been dedicated to understanding the efficacy of prevention/intervention programs delivered within these contexts.

William Martinez, Ph.D. is an Assistant Professor in the Department of Psychiatry at the University of California, San Francisco and Director of the Child and Adolescent Services clinic in the Division of Infant, Child, and Adolescent Psychiatry at Zuckerberg San Francisco General Hospital. He completed his doctoral training through DePaul University in Clinical-Child Psychology, an APA-accredited internship in the UCSF/ZSFG Multicultural Clinical Training Program, and a NIH-funded postdoc at UC Berkeley in the School of Public Health. He is faculty with two APA-accredited internship programs at UCSF/ZSFG - the Multicultural Clinical Training Program and the Clinical Psychology Training Program.

Angelina Romano, MSW/PPS is a school social worker and District Coordinator for San Francisco Unified School District's Refugee and Immigrant Supports in Education (RISE-SF), a k-12 program focusing on school-based Newcomer Immigrant Programming and Sanctuary Education. Angelina has lived and worked in the San Francisco Bay Area since 2001, and began serving the immigrant community at SFUSD after graduating UC Berkeley, School of Social Welfare in 2007. In 2014, in response to the humanitarian crisis of young people and families fleeing violence and crossing the U.S. southern border, Angelina founded RISE-SF to serve as a centralized, district-wide program to serve this population and to collaborate with community-based organizations to ensure their needs were being met in and out of school.



STAFF ANALYSIS — SAN FRANCISCO COUNTY

Innovation (INN) Project Name: *Fuerte School-Based Prevention Groups*
Total INN Funding Requested: **\$1,500,000**
Duration of Innovative Project: **Five (5) Years**

Review History:

Approved by the County Board of Supervisors: October 30, 2018
County submitted INN Project: October 16, 2018
MHSOAC consideration of INN Project: January 24, 2018

Project Introduction:

The *Fuerte* program is proposed as an adaptation of a promising school-based prevention approach to promote support around acculturation and behavioral health access for newcomer Latinx immigrant youth (ages 12 to 18 who have migrated within the past 5 years) in the San Francisco Unified School District. By introducing this adaptation into the mental health system of California, San Francisco County hopes to reduce behavioral health disparities among newcomer youth and create a “playbook” that other counties can use to adopt and implement the groups for other immigrant populations. The “playbook” will be developed using a mixed-methods approach as part of a comprehensive evaluation.

San Francisco County will accomplish the goals of the *Fuerte* program through an ongoing collaboration between the San Francisco Unified School District, the San Francisco Department of Public Health, community-based providers and the Departments of Psychiatry and Pediatrics at the University of California, San Francisco.

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

San Francisco County states that approximately 500 newcomer Latinx adolescents (ages 12 to 18 who have migrated within the past 5 years) enroll in local schools every year. The County asserts that these youth are at a higher risk of health disparities, both physical and mental, for many reasons including resource constraints and exposure to traumatic events. Research supports the County's assertions that newcomer youth are particularly vulnerable to mental health challenges (National Association of School Psychologists, 2015) and highlights a lack of culturally appropriate outreach and accessible resources for adolescents (Morse, 2005).

In response to the needs of newcomer youth and the lack of a validated, culturally appropriate curriculum designed to promote linkage to services, a collaboration between University of California, San Francisco pediatricians and psychologists was formed to implement an innovative school-based prevention program, *Fuerte*. The *Fuerte* collaborative grew into a shared initiative between the San Francisco Unified School District, Department of Public Health, community-based organizations, medical providers, and behavioral health personnel.

The *Fuerte* collaborative initiated a pilot in 2014 and has since served over 150 adolescents at 9 different schools. Funding for the pilot was provided through in-kind staff support from the participating university, school district and Department of Public Health.

The six-week curriculum is based around increasing mental health literacy, strengthening social connections, coping & communication skills, and is delivered in weekly group sessions. The curriculum was developed using various evidence-based approaches, including the Attachment, Regulation, and Competency (ARC) framework and adapted to highlight three targets for prevention programming: 1) increased social connectedness; 2) adolescent self-regulatory capacity; and 3) developmental competency through building or restoring resilience. Feedback from newcomer immigrant youth and their families, as well as providers also influenced the adaptation.

In the pilot, group participants were screened using the Pediatric Symptoms Checklist which revealed that a significant number screened positive for mental health symptoms. In addition, anecdotal data from the district's Wellness Centers suggest that the newcomer youth present with significant stressors and symptoms such as anxiety, depression, and trauma, but are unlikely to access behavioral health resources.

The Collaborative reports that preliminary data from the pilot period suggests that implementing the program is feasible and that youth who participated in the program experience positive outcomes. However, no formal evaluation has been completed and is the next step of the project.

The Response

In order to test the effectiveness of the *Fuerte* model at reducing mental health disparities of newcomer immigrants by increasing screenings, engagement and referrals to specialty mental health services (when appropriate), San Francisco County proposes to use innovation funds to expand the number of groups and conduct a comprehensive evaluation while also creating a “playbook” to share with other counties for use.

Specifically, San Francisco County will use innovation funds to oversee the operations and management to scale up the project and conduct a comprehensive evaluation. Clinicians within the collaboration will continue in kind contributions to operate some groups with additional, per diem, clinicians hired to support the added groups. The per diem clinicians will also participate in the evaluation that will inform the development of the playbook.

Research shows that there are many programs serving newcomer adolescents both nationally and internationally but that evaluations of existing programs are lacking. Research confirms the need for evaluations to assess the effectiveness of programs designed for newcomer youth in order to inform policy makers and support system change (Morse, 2005).

In addition, San Francisco County’s *Fuerte* innovation proposal appears to be in-line with the Commission’s efforts to support the mental health needs of the Immigrant and Refugee community as evidenced by the ongoing community listening sessions and upcoming Request for Proposal. Specifically, the Commission understands that Immigrant and Refugee populations often experience what is called “triple traumas” beginning with trauma in their countries of origin, trauma in the actual move, and then trauma in acculturation. Newcomer students face the trauma of acculturation while trying to learn thus impacting their ability to perform well, manage their emotions and attention, and develop positive relationships (“Helping Traumatized Children Learn,” n.d.).

The Commission is also investing \$21 million in four school-based collaborations focused on transforming the culture around mental wellness in schools. San Francisco County’s approach may be part of the solution to increase mental health literacy and access to services in schools.

An exciting outcome of the proposed project is the **free** dissemination of the “playbook” for other counties to use and adopt for other immigrant populations. A train-the-trainer model will be part of the dissemination.

The Community Planning Process

The vision for *Fuerte* was a result of a community needs assessment in the summer of 2015. Four focus groups of newcomer Latinx youth, their parents, educators and mental health providers were held and identified the urgent need for school-based mental health resources for newcomer Latinx youth.

All printed and electronic material were printed in Spanish, Mandarin and other languages (as needed). Translation services were provided at all meetings.

An additional eighteen community engagement meetings were held throughout 2017 and 2018 and the *Fuerte* project was part of the input gathering process. Community input resulted in the current project. Key changes made by stakeholders included the development of a “playbook” for adapting and disseminating *Fuerte* to other counties for use with additional populations (including but not limited to: Middle Eastern immigrants). Stakeholders want to ensure that other counties understand the importance of collaboration between Public Health officials, the school districts, community-based providers and engagement with the local immigrant communities. Community input also ensured that the project is culturally informed by the Latinx immigrant experience.

The County reports receiving no comments during the 30-day public posting of this project from July 2, 2018 through August 1, 2018.

This proposal was shared with MHSOAC stakeholders on October 11, 2018. In response, MHSOAC staff received one email from California Pan-Ethnic Health Network (CPEHN) in support of the proposal.

Learning Objectives and Evaluation

San Francisco County plans on implementing an adaptation of a prevention program aimed at reducing behavioral health disparities among Latinx newcomer youth. The County states that the program will serve three primary purposes: (1) increase access to mental health services for underserved groups; (2) increase the quality of mental health services, including measurable outcomes; and (3) promote interagency and community collaboration. The County will target Latinx newcomer youth ages 12 to 18 in the San Francisco Unified School District (SFUSD). It is the hope that approximately 100-youth will be served annually for a total of 400-youth served during the duration of the project.

Design

San Francisco County has developed a thorough evaluation plan that will utilize a cluster randomized control trial to meet the primary purposes of the *Fuerte* project. The County states that at least eight SFUSD schools will participate in the project, with schools being randomly assigned to either the *Fuerte* intervention group or into a delayed waitlist control (DWC) group. Students assigned to the *Fuerte* intervention group will receive the

intervention in the fall semester, while students assigned to the DWC group will receive the intervention in the spring semester¹.

Methods

To guide their project, the County has identified five main learning questions:

1. Does *Fuerte* increase the mental health literacy of newcomer Latinx immigrant youth?
2. Does *Fuerte* increase behavioral health access among Latinx newcomer youth?
3. Does *Fuerte* increase youth's social connectedness?
4. In order to adapt the curriculum to other populations, how do clinicians make decisions regarding tailoring the *Fuerte* curriculum?
5. What are the requirements needed for interagency and partner collaborations in order to make implementation of *Fuerte* possible in other counties?

In addition to these learning questions, the County has identified several intended short term, medium term, and long term *outcomes* from the project (**see logic model on pg. 8 of County plan**). To determine if outcomes are met, the County will assess a number of *measures*, including:

- Measures of knowledge (relative to trauma, coping mechanisms for traumatic stress, and the mental health system)
- Access to services (using the Pediatric Symptom Checklist for screening, and referrals to mental health services), and
- Social connectedness (using a social connectedness scale; **see pgs. 11-13 of County Plan**).

To collect the data necessary for evaluation, the County will administer surveys to participants pre-intervention, post-intervention, as well as 3-months post-intervention. Additionally, the County will hold semi-structured interviews from key stakeholders, and behavioral health providers in San Francisco County community-based organizations to gather information relative to program adaptation and collaboration.

The San Francisco Mental Health Services Act team will work with the San Francisco Department of Quality Management to evaluate the program, develop the tools necessary, and complete the final evaluation plan. Overall, San Francisco County's evaluation plan is a comprehensive examination of the extent to which the *Fuerte* program increases access to mental health services among Latinx newcomers, improves quality of services, as well as promotes interagency collaboration. At the conclusion of the *Fuerte* program, results and lessons learned will be shared with key stakeholders, and used to

¹The County has noted that students assigned to the control group that exhibit significant behavioral health symptoms during the pre-intervention phase will be referred to specialty mental health services.

develop an adaptation playbook to assist other counties or jurisdictions interested in implementing the *Fuerte* program.

The Budget

The County is requesting \$300,000 in innovation dollars annually, for a total budget of \$1,500,000 over five years. The majority of spending, \$929,481 (including \$99,587 indirect costs) will go toward personnel costs to manage the project and carry out the evaluation. These positions include a 0.2 FTE Project Director, 1.0 FTE Project Coordinator and 0.01 FTE Statistician.

Additional evaluation costs are budgeted at \$296,519 (5% of total budget).

Operating expenses total \$125,000 and training expenses total \$25,000.

The County has budgeted \$110,000 for clinical and subject matter consultants and \$14,000 for one time equipment costs.

There is an in-kind contribution of staff time from the collaborative partners for programming and evaluation support.

The County is not using funds subject to reversion or deemed reverted for this project.

If determined to be effective, the project will be sustained through leveraged partnerships and Prevention and Early Intervention funds or other State/Federal grants.

Additional Regulatory Requirements

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

References

Helping Traumatized Children Learn (n.d). Retrieved from:

<https://traumasensitiveschools.org/trauma-and-learning/the-problem-impact/>

Morse, Ann (2005). A Look at Immigrant Youth: Prospects and Promising Practices. Retrieved from: <http://www.ncsl.org/research/immigration/a-look-at-immigrant-youth-prospects-and-promisin.aspx>

National Association of School Psychologists (2015). Supporting Refugee Children & Youth: Tips for Educators. Retrieved From: <https://www.nasponline.org/resources-and-publications/resources/school-safety-and-crisis/war-and-terrorism/supporting-refugee-students>

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2019-01/fuerte-school-based-prevention-groups-san-francisco-county-innovation-plan>

Dear Mental Health Services Oversight and Accountability Commission:

The California Pan-Ethnic Health Network (CPEHN) is writing to submit comments in response to the opportunity to provide feedback regarding San Francisco County Innovation Project: Fuerte School-Based Prevention Groups. We ask the Mental Health Services Oversight and Accountability Commission to approve the San Francisco Department of Public Health's *Fuerte* School-Base Prevention Groups Innovation Project Proposal.

We applaud San Francisco Department of Public Health's *Fuerte* School-Based Prevention Groups Innovations Project Proposal's because of its plans to address mental health disparities in communities of color, specifically Latinx youth and their caregivers.

Innovations provides an enormous opportunity to develop programs that can meet the diverse needs of immigrants and immigrant families. The use of Innovations to address the diverse needs of immigrants and immigrant families is especially urgent given the documented impact of the current anti-immigrant climate on immigrant communities.

Data gathered in a provider surveyed conducted by CPCA, The Children's Partnership and the California Program on Access to Care in September of 2017 shows high increases in fear, anxiety and depression among this population. Additionally, preliminary findings from CPEHN's Summer 2018 research on access to mental health services among immigrant communities underscores the central role public mental health services, Innovations in particular, plays in the mental health treatment of immigrants and immigrant families, particularly those who experience fears relating to documentation status and mental health stigma.

To this end, we support San Francisco Department of Public Health's Innovations Project Proposal's investment in co-location of behavioral health services at schools to help expand the reach of mental health providers, increase screenings and triage of youth, and decrease overall barriers to treatment.

Sincerely,

Carolina Valle
Senior Policy Associate, California Pan-Ethnic Health Network

AGENDA ITEM 7

Action

January 24, 2019 Commission Meeting

Legislative Priorities

Summary: The Commission will consider legislative and budget priorities for the current legislative session. In addition, the Commission has been asked by the authors to consider taking a position on the following bills: Senate Bill 10 (Beall), Senate Bill 11 (Beall), Senate Bill 12 (Beall), and AB 46 (Carrillo).

- **Senate Bill 10 (Beall):** Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program.
- **Senate Bill 11 (Beall):** Would require a health care service plan and a health insurer to submit an annual report to the Department of Managed Health Care or the Department of Insurance, as appropriate, certifying compliance with state and federal mental health parity laws, as specified. The bill would require the departments to review the reports submitted by health care service plans to ensure compliance with state and federal mental health parity laws, and would require the departments to make the reports and the results of the reviews available upon request and to post the reports and the results of the reviews on the departments' Internet Web site.
- **Senate Bill 12 (Beall):** Would authorize the state and local governments to establish a series of at least 100 centers statewide to address the mental health needs of California youth. The bill would declare the intent of the Legislature to enact legislation to allocate or encourage the allocation of funding for that purpose, as specified. The bill would make related findings and declarations.
- **Assembly Bill 46 (Carrillo):** Replace derogatory terms, including, but not limited to, "insane" and "mentally defective," with more culturally sensitive terms when referring to individuals with mental illness.

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Norma Pate, Deputy Director, MHSOAC
- Greg Cramer, Policy Consultant, Office of Senator Beall
- Samantha Samuelsen, Legislative Aide, Office of Assemblymember Carrillo

Enclosures (4): Senate Bill 10 (Beall), Senate Bill 11 (Beall), and Senate Bill 12 (Beall), and Assembly Bill 46 (Carrillo).

Handout: None

Proposed Motion: The MHSOAC authorizes the Executive Director to pursue discussions with the Legislature to support or sponsor legislation consistent with the direction given by the Commission.

Introduced by Senator BeallDecember 3, 2018

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 10, as introduced, Beall. Mental health services: peer, parent, transition-age, and family support specialist certification.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also requires funds to be reserved for the costs of the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OSHPD), the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to certain programs provided for by the act, subject to appropriation in the annual Budget Act. The act provides that it may be amended by the Legislature by a $\frac{2}{3}$ vote of each house as long as the amendment is consistent with,

and furthers the intent of, the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialist, transition-age youth peer support specialist, family peer support specialist, and parent peer support specialist. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, establishing a code of ethics, and determining a certification revocation process. The bill would require an applicant for the certification as a peer, parent, transition-age, or family support specialist to meet specified requirements, including successful completion of the curriculum and training requirements.

This bill would require the department to consult with OSHPD and other stakeholders in implementing the certification program, including requiring quarterly stakeholder meetings. The bill would authorize the department to use funding provided through the MHSA, upon appropriation, to develop and administer the certification program, and would authorize the use of these MHSA funds to serve as the state's share of funding to claim federal financial participation under the Medicaid Program.

This bill would authorize the department to establish a certification fee schedule and to require remittance of fees as contained in the schedule, for the purpose of supporting the department's activities associated with the ongoing administration of the certification program.

This bill would require Medi-Cal reimbursement for peer support specialist services to be implemented only if, and to the extent that, federal financial participation is available and the department obtains all necessary federal approvals. The bill also would authorize the department to implement, interpret, or make specific its provisions by means of informational notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2022, and, commencing July 1, 2020, would require the

department to provide semiannual status reports to the Legislature until regulations have been adopted.

This bill would declare that it clarifies terms and procedures under the Mental Health Services Act.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Article 1.4 (commencing with Section 14045.10)
2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
3 Institutions Code, to read:

4
5 Article 1.4. Peer, Parent, Transition-Age, and Family Support
6 Specialist Certification Program
7

8 14045.10. This article shall be known, and may be cited, as
9 the Peer, Parent, Transition-Age, and Family Support Specialist
10 Certification Act of 2019.

11 14045.11. The Legislature finds and declares all of the
12 following:

13 (a) With the enactment of the Mental Health Services Act in
14 2004, support to include peer providers identified as consumers,
15 parents, and family members for the provision of services has been
16 on the rise.

17 (b) There are over 6,000 peer providers in California who
18 provide individualized support, coaching, facilitation, and
19 education to clients with mental health care needs and substance
20 use disorder, in a variety of settings, yet no statewide scope of
21 practice, standardized curriculum, training standards, supervision
22 standards, or certification protocol is available.

23 (c) The United States Department of Veterans Affairs and over
24 30 states utilize standardized curricula and certification protocols
25 for peer support services.

26 (d) The federal Centers for Medicare and Medicaid Services
27 (CMS) recognizes that the experiences of peer support specialists,
28 as part of an evidence-based model of care, can be an important
29 component in a state's delivery of effective mental health and
30 substance use disorder treatment. The CMS encourages states to
31 offer comprehensive programs.

1 (e) A substantial number of research studies demonstrate that
2 peer supports improve client functioning, increase client
3 satisfaction, reduce family burden, alleviate depression and other
4 symptoms, reduce hospitalizations and hospital days, increase
5 client activation, and enhance client self-advocacy.

6 (f) Certification can encourage an increase in the number,
7 diversity, and availability of peer support specialists.

8 14045.12. It is the intent of the Legislature that the peer, parent,
9 transition-age, and family support specialist certification program,
10 established under this article, achieve all of the following:

11 (a) Support the ongoing provision of services for beneficiaries
12 experiencing mental health care needs, substance use disorder
13 needs, or both by certified peer support specialists.

14 (b) Support coaching, linkage, and skill building of beneficiaries
15 with mental health needs, substance use disorder needs, or both,
16 and to families or significant support persons.

17 (c) Increase family support by building on the strengths of
18 families and helping them achieve a better understanding of mental
19 illness in order to help beneficiaries achieve desired outcomes.

20 (d) Provide part of a continuum of services, in conjunction with
21 other community mental health services and other substance use
22 disorder treatment.

23 (e) Collaborate with others providing care or support to the
24 beneficiary or family.

25 (f) Assist parents, families, and beneficiaries in developing
26 coping mechanisms and problem-solving skills in order to help
27 beneficiaries achieve desired outcomes.

28 (g) Promote skill building for beneficiaries in the areas of
29 socialization, recovery, self-sufficiency, self-advocacy,
30 development of natural supports, and maintenance of skills learned
31 in other support services.

32 (h) Encourage employment under the peer, parent, transition-age,
33 and family support specialist certification to reflect the culture,
34 ethnicity, sexual orientation, gender identity, mental health service
35 experiences, and substance use disorder experiences of the people
36 whom they serve.

37 14045.13. For purposes of this article, the following definitions
38 shall apply:

39 (a) “Adult peer support specialist” means a person who is 18
40 years of age or older and who has self-identified as having lived

1 experience of recovery from mental illness, substance use disorder,
2 or both, and the skills learned in formal training to deliver peer
3 support services in a behavioral setting to promote mind-body
4 recovery and resiliency for adults.

5 (b) “Certification” means the activities of the certifying body
6 related to the verification that an individual has met all of the
7 requirements under this article and that the individual may provide
8 mental health services and substance use disorder treatment
9 pursuant to this article.

10 (c) “Certified” means all federal and state requirements have
11 been satisfied by an individual who is seeking designation under
12 this article, including completion of curriculum and training
13 requirements, testing, and agreement to uphold and abide by the
14 code of ethics.

15 (d) “Code of ethics” means the standards to which a peer support
16 specialist is required to adhere.

17 (e) “Core competencies” are the foundational and essential
18 knowledge, skills, and abilities required for peer specialists.

19 (f) “Cultural competence” means a set of congruent behaviors,
20 attitudes, and policies that come together in a system or agency
21 that enables that system or agency to work effectively in
22 cross-cultural situations. A culturally competent system of care
23 acknowledges and incorporates, at all levels, the importance of
24 language and culture, intersecting identities, assessment of
25 cross-cultural relations, knowledge and acceptance of dynamics
26 of cultural differences, expansion of cultural knowledge, and
27 adaptation of services to meet culturally unique needs to provide
28 services in a culturally competent manner.

29 (g) “Department” means the State Department of Health Care
30 Services.

31 (h) “Family peer support specialist” means a person with lived
32 experience as a self-identified family member of an individual
33 experiencing mental illness, substance use disorder, or both, and
34 the skills learned in formal training to assist and empower families
35 of individuals experiencing mental illness, substance use disorder,
36 or both. For the purpose of this subdivision, “family member”
37 includes a sibling or kinship caregiver, and a partner of that family
38 member.

39 (i) “Parent” means a person who is parenting or has parented a
40 child or individual experiencing mental illness, substance use

1 disorder, or both, and who can articulate his or her understanding
2 of his or her experience with another parent or caregiver. This
3 person may be a birth parent, adoptive parent, or family member
4 standing in for an absent parent.

5 (j) “Parent peer support specialist” means a parent with formal
6 training to assist and empower families parenting a child or
7 individual experiencing mental illness, substance use disorder, or
8 both.

9 (k) “Peer support specialist services” means culturally competent
10 services that promote engagement, socialization, recovery,
11 self-sufficiency, self-advocacy, development of natural supports,
12 identification of strengths, and maintenance of skills learned in
13 other support services. Peer support specialist services shall
14 include, but are not limited to, support, coaching, facilitation, or
15 education to Medi-Cal beneficiaries that is individualized to the
16 beneficiary and is conducted by a certified adult peer support
17 specialist, a certified transition-age youth peer support specialist,
18 a certified family peer support specialist, or a certified parent peer
19 support specialist.

20 (l) “Recovery” means a process of change through which an
21 individual improves his or her health and wellness, lives a
22 self-directed life, and strives to reach his or her full potential. This
23 process of change recognizes cultural diversity and inclusion, and
24 honors the different routes to resilience and recovery based on the
25 individual and his or her cultural community.

26 (m) “Transition-age youth peer support specialist” means a
27 person who is 18 years of age or older and who has self-identified
28 as having lived experience of recovery from mental illness,
29 substance use disorder, or both, and the skills learned in formal
30 training to deliver peer support services in a behavioral setting to
31 promote mind-body recovery and resiliency for transition-age
32 youth, including adolescents and young adults.

33 14045.14. No later than July 1, 2020, the department shall do
34 all of the following:

35 (a) Establish a certifying body, either through contract or through
36 an interagency agreement, to provide for the certification activities
37 described in this article.

38 (b) Provide for a statewide certification for each of the following
39 categories of peer support specialists, as contained in federal

1 guidance issued by the Centers for Medicare and Medicaid
2 Services, State Medicaid Director Letter (SMDL) #07-011:

3 (1) Adult peer support specialists, who may serve individuals
4 across the lifespan.

5 (2) Transition-age youth peer support specialists.

6 (3) Family peer support specialists.

7 (4) Parent peer support specialists.

8 (c) Define the range of responsibilities and practice guidelines
9 for the categories of peer support specialists listed in subdivision
10 (b), by utilizing best practice materials published by the federal
11 Substance Abuse and Mental Health Services Administration, the
12 federal Department of Veterans Affairs, and related notable experts
13 in the field as a basis for development.

14 (d) Determine curriculum and core competencies required for
15 certification of an individual as a peer support specialist, including
16 curriculum that may be offered in areas of specialization, including,
17 but not limited to, transition-age youth, veterans, gender identity,
18 sexual orientation, and any other areas of specialization identified
19 by the department. Core competencies-based curriculum shall
20 include, at a minimum, training related to all of the following
21 elements:

22 (1) The concepts of hope, recovery, and wellness.

23 (2) The role of advocacy.

24 (3) The role of consumers and family members.

25 (4) Psychiatric rehabilitation skills and service delivery, and
26 addiction recovery principles, including defined practices.

27 (5) Cultural competence training.

28 (6) Trauma-informed care.

29 (7) Group facilitation skills.

30 (8) Self-awareness and self-care.

31 (9) Cooccurring disorders of mental health and substance use.

32 (10) Conflict resolution.

33 (11) Professional boundaries and ethics.

34 (12) Safety and crisis planning.

35 (13) Navigation of, and referral to, other services.

36 (14) Documentation skills and standards.

37 (15) Study and test-taking skills.

38 (16) Confidentiality.

39 (e) Specify training requirements, including
40 core-competencies-based training and specialized training

1 necessary to become certified under this article, allowing for
2 multiple qualified training entities, and requiring training to include
3 people with lived experience as consumers and family members.

4 (f) Establish a code of ethics.

5 (g) Determine continuing education requirements for biennial
6 certification renewal.

7 (h) Determine the process for biennial certification renewal.

8 (i) Determine a process for investigation of complaints and
9 corrective action, which may include suspension and revocation
10 of certification.

11 (j) Determine a process for an individual employed as a peer
12 support specialist on January 1, 2020, to obtain certification under
13 this article.

14 14045.15. (a) In order to be certified as an adult peer support
15 specialist, an individual shall, at a minimum, satisfy all of the
16 following requirements:

17 (1) Be at least 18 years of age.

18 (2) Have or have had a primary diagnosis of mental illness,
19 substance use disorder, or both, that is self-disclosed.

20 (3) Have received, or be receiving, mental health services,
21 substance use disorder services, or both.

22 (4) Be willing to share his or her experience of recovery.

23 (5) Demonstrate leadership and advocacy skills.

24 (6) Have a strong dedication to recovery.

25 (7) Agree, in writing, to abide by a code of ethics. A copy of
26 the code of ethics shall be signed by the applicant.

27 (8) Successfully complete the curriculum and training
28 requirements for an adult peer support specialist.

29 (9) Pass a certification examination approved by the department
30 for an adult peer support specialist.

31 (10) Successfully complete any required continuing education,
32 training, and recertification requirements.

33 (11) Meet all applicable federal requirements.

34 (b) To maintain certification pursuant to this section, an adult
35 peer support specialist shall do both of the following:

36 (1) Abide by the code of ethics and biennially sign an
37 affirmation.

38 (2) Complete any required continuing education, training, and
39 recertification requirements.

1 14045.16. (a) In order to be certified as a transition-age youth
2 peer support specialist, an individual shall, at a minimum, satisfy
3 all of the following requirements:

- 4 (1) Be at least 18 years of age.
- 5 (2) Have or have had a primary diagnosis of mental illness,
6 substance use disorder, or both, that is self-disclosed.
- 7 (3) Have received, or be receiving, mental health services,
8 substance use disorder addiction services, or both.
- 9 (4) Be willing to share his or her experience of recovery.
- 10 (5) Demonstrate leadership and advocacy skills.
- 11 (6) Have a strong dedication to recovery.
- 12 (7) Agree, in writing, to abide by a code of ethics. A copy of
13 the code of ethics shall be signed by the applicant.
- 14 (8) Successfully complete the curriculum and training
15 requirements for a transition-age youth peer support specialist.
- 16 (9) Meet all applicable federal requirements.

17 (b) To maintain certification pursuant to this section, a
18 transition-age youth peer support specialist shall do both of the
19 following:

- 20 (1) Abide by the code of ethics and biennially sign an
21 affirmation.
- 22 (2) Complete any required continuing education, training, and
23 recertification requirements.

24 14045.17. (a) In order to be certified as a family peer support
25 specialist, an individual shall, at a minimum, satisfy all of the
26 following requirements:

- 27 (1) Be at least 18 years of age.
- 28 (2) Be self-identified as a family member of an individual
29 experiencing mental illness, substance use disorder, or both.
- 30 (3) Be willing to share his or her experience.
- 31 (4) Demonstrate leadership and advocacy skills.
- 32 (5) Have a strong dedication to recovery.
- 33 (6) Agree, in writing, to abide by a code of ethics. A copy of
34 the code of ethics shall be signed by the applicant.
- 35 (7) Successfully complete the curriculum and training
36 requirements for a family peer support specialist.
- 37 (8) Pass a certification examination approved by the department
38 for a family peer support specialist.
- 39 (9) Meet all applicable federal requirements.

1 (b) To maintain certification pursuant to this section, a family
2 peer support specialist shall do both of the following:

3 (1) Abide by the code of ethics and biennially sign an
4 affirmation.

5 (2) Complete any required continuing education, training, and
6 recertification requirements.

7 14045.18. (a) In order to be certified as a parent peer support
8 specialist, an individual shall, at a minimum, satisfy all of the
9 following requirements:

10 (1) Be at least 18 years of age.

11 (2) Be self-identified as a parent.

12 (3) Be willing to share his or her experience.

13 (4) Demonstrate leadership and advocacy skills.

14 (5) Have a strong dedication to recovery.

15 (6) Agree, in writing, to abide by a code of ethics. A copy of
16 the code of ethics shall be signed by the applicant.

17 (7) Successfully complete the curriculum and training
18 requirements for a parent peer support specialist.

19 (8) Meet all applicable federal requirements.

20 (b) To maintain certification pursuant to this section, a parent
21 peer support specialist shall do both of the following:

22 (1) Abide by the code of ethics and biennially sign an
23 affirmation.

24 (2) Complete any required continuing education, training, and
25 recertification requirements.

26 14045.19. (a) This article shall not be construed to imply that
27 an individual who is certified pursuant to this article is qualified
28 to, or authorized to, diagnose an illness, prescribe medication, or
29 provide clinical services.

30 (b) This article does not alter the scope of practice for a health
31 care professional or authorize the delivery of health care services
32 in a setting or manner that is not authorized pursuant to the
33 Business and Professions Code or the Health and Safety Code.

34 14045.20. The department shall consult with the Office of
35 Statewide Health Planning and Development (OSHPD), peer
36 support and family organizations, mental health services and
37 substance use disorder treatment providers and organizations, the
38 County Behavioral Health Directors Association of California,
39 and the California Behavioral Health Planning Council in
40 implementing this article. Consultation shall initially include, at

1 a minimum, quarterly stakeholder meetings. The department may
2 additionally conduct technical workgroups upon the request of
3 stakeholders.

4 14045.21. To facilitate early intervention for mental health
5 services, community health workers may partner with peer, parent,
6 transition-age, and family support specialists to improve linkage
7 to services for the beneficiary.

8 14045.22. The Legislature does not intend, in enacting this
9 article, to modify the Medicaid state plan in any manner that would
10 otherwise change or nullify the requirements, billing, or
11 reimbursement of the “other qualified provider” provider type, as
12 currently authorized by the Medicaid state plan.

13 14045.23. The department may utilize Mental Health Services
14 Act moneys to fund state administrative costs related to developing
15 and administering this article, subject to an express appropriation
16 in the annual Budget Act for these purposes, and to the extent
17 authorized under the Mental Health Services Act. These funds
18 shall be available for purposes of claiming federal financial
19 participation under Title XIX of the federal Social Security Act
20 (42 U.S.C. Sec. 1396), contingent upon federal approval.

21 14045.24. Medi-Cal reimbursement for peer support specialist
22 services shall be implemented only if, and to the extent that, federal
23 financial participation under Title XIX of the federal Social
24 Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all
25 necessary federal approvals have been obtained.

26 14045.25. The department may establish a certification fee
27 schedule and may require remittance as contained in the
28 certification fee schedule for the purpose of supporting the
29 activities associated with the ongoing administration of the peer,
30 parent, transition-age, and family support specialist certification
31 program. Certification fees charged by the department shall
32 reasonably reflect the expenditures directly applicable to the
33 ongoing administration of the peer, parent, transition-age, and
34 family support specialist certification program.

35 14045.26. For the purpose of implementing this article, the
36 department may enter into exclusive or nonexclusive contracts on
37 a bid or negotiated basis, including contracts for the purpose of
38 obtaining subject matter expertise or other technical assistance.

39 14045.27. Notwithstanding Chapter 3.5 (commencing with
40 Section 11340) of Part 1 of Division 3 of Title 2 of the Government

1 Code, the department may implement, interpret, or make specific
2 this article by means of informal notices, plan letters, plan or
3 provider bulletins, or similar instructions, without taking regulatory
4 action, until the time regulations are adopted. The department shall
5 adopt regulations by July 1, 2022, in accordance with the
6 requirements of Chapter 3.5 (commencing with Section 11340) of
7 Part 1 of Division 3 of Title 2 of the Government Code.
8 Commencing July 1, 2020, the department shall provide semiannual
9 status reports to the Legislature, in compliance with Section 9795
10 of the Government Code, until regulations have been adopted.

11 SEC. 2. The Legislature finds and declares that this act clarifies
12 procedures and terms of the Mental Health Services Act within
13 the meaning of Section 18 of the Mental Health Services Act.

Introduced by Senator BeallDecember 3, 2018

An act to add Sections 1374.77 and 1374.78 to the Health and Safety Code, and to add Sections 10144.41 and 10144.42 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 11, as introduced, Beall. Health care coverage: mental health parity.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts or health insurance policies issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.

Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires group health plans and health insurance issuers that provides both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. Existing state law subjects nongrandfathered individual and small group health care

service plan contracts and health insurance policies that provide coverage for essential health benefits to those provisions of the MHPAEA.

This bill would require a health care service plan and a health insurer to submit an annual report to the Department of Managed Health Care or the Department of Insurance, as appropriate, certifying compliance with state and federal mental health parity laws, as specified. The bill would require the departments to review the reports submitted by health care service plans to ensure compliance with state and federal mental health parity laws, and would require the departments to make the reports and the results of the reviews available upon request and to post the reports and the results of the reviews on the departments' Internet Web site. The bill would also require the departments to report to the Legislature the information obtained through the reports and the results of the review of the reports and on all other activities taken to enforce state and federal mental health parity laws.

Existing law authorizes a health care service plan and a health insurer to utilize formularies, prior authorization, step therapy, or other reasonable medical management practices, as specified, in the provision of outpatient prescription drug coverage.

The bill would prohibit a health care service plan and a health insurer that provides prescription drug benefits for the treatment of substance use disorders from, among other things, imposing any prior authorization requirements on, or any step therapy requirements before authorizing coverage for, a prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorders.

Because a willful violation of the bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1374.77 is added to the Health and Safety
2 Code, to read:

3 1374.77. (a) A health care service plan shall submit an annual
4 report to the department on or before March 1 of each year
5 certifying compliance with Sections 1374.72, 1374.76, and
6 1374.78, and the federal Paul Wellstone and Pete Domenici Mental
7 Health Parity and Addiction Equity Act of 2008 (Public Law
8 110-343), hereafter referred to as the MHPAEA, its implementing
9 regulations, and all related federal guidance. The department shall
10 make the report available upon request and shall post the report
11 on the department's Internet Web site.

12 (b) A health care service plan shall include, but not be limited
13 to, all of the following information in the annual report required
14 pursuant to subdivision (a):

15 (1) A description of the process used to develop or select the
16 medical necessity criteria for mental health and substance use
17 disorder benefits and the process used to develop or select the
18 medical necessity criteria for medical and surgical benefits.

19 (2) Identification of all nonquantitative treatment limitations
20 (NQTLs) that are applied to both mental health and substance use
21 disorder benefits and medical and surgical benefits within each
22 classification of benefits.

23 (3) The results of an analysis that demonstrates that for the
24 medical necessity criteria described in paragraph (1) and for each
25 NQTL identified in paragraph (2), as written and in operation, the
26 processes, strategies, evidentiary standards, or other factors used
27 in applying the medical necessity criteria and each NQTL to mental
28 health and substance use disorder benefits within each classification
29 of benefits are comparable to, and are applied no more stringently
30 than, the processes, strategies, evidentiary standards, or other
31 factors used in applying the medical necessity criteria and each
32 NQTL to medical and surgical benefits within the corresponding
33 classification of benefits. At a minimum, the results of the analysis
34 shall do all of the following:

35 (A) Identify the factors used to determine that an NQTL will
36 apply to a benefit, including factors that were considered, but
37 rejected.

1 (B) Identify and define the specific evidentiary standards used
2 to define the factors and any other evidence relied upon in
3 designing each NQTL.

4 (C) Provide the comparative analyses, including the results of
5 the analyses performed to determine that the processes and
6 strategies used to design each NQTL, as written, and the written
7 processes and strategies used to apply the NQTL to mental health
8 and substance use disorder benefits are comparable to, and are
9 applied no more stringently than, the processes and strategies used
10 to design each NQTL, as written, and the written processes and
11 strategies used to apply the NQTL to medical and surgical benefits.

12 (D) Provide the comparative analyses, including the results of
13 the analyses performed to determine that the processes and
14 strategies used to apply each NQTL, in operation, for mental health
15 and substance use disorder benefits are comparable to, and are
16 applied no more stringently than, the processes or strategies used
17 to apply each NQTL, in operation, for medical and surgical
18 benefits.

19 (E) Disclose the specific findings and conclusions reached by
20 the health care service plan that the results of the analyses described
21 in this paragraph indicate that the health care service plan is in
22 compliance with the MHPAEA, its implementing regulations, and
23 all related federal guidance.

24 (c) A report submitted to the department pursuant to this section
25 shall not include any information that may individually identify
26 insureds, including, but not limited to, medical record numbers,
27 names, and addresses.

28 (d) The department shall review the reports submitted by health
29 care service plans pursuant to subdivision (a) to ensure compliance
30 with this section, Sections 1374.72, 1374.76, and 1374.78, and the
31 MHPAEA, its implementing regulations, and all related federal
32 guidance. The department shall make the results of the review
33 available upon request and shall post the review of the reports on
34 the department's Internet Web site.

35 (e) (1) The department shall annually report to the Legislature
36 the information obtained through the reports and the results of the
37 review of the reports and on all other activities taken to enforce
38 this section, Sections 1374.72, 1374.76, and 1374.78, and the
39 MHPAEA, its implementing regulations, and all related federal
40 guidance.

1 (2) The California State Auditor shall review the department’s
2 implementation of this section, and shall report its findings from
3 the review to the Legislature.

4 (3) A report submitted pursuant to this subdivision shall be
5 submitted in accordance with Section 9795 of the Government
6 Code.

7 (f) For purposes of this section, “nonquantitative treatment
8 limitations” or “NQL” means those limitations described in the
9 implementing regulations of the MHPAEA.

10 SEC. 2. Section 1374.78 is added to the Health and Safety
11 Code, to read:

12 1374.78. Notwithstanding any other law, a health care service
13 plan that provides prescription drug benefits for the treatment of
14 substance use disorders shall place all prescription medications
15 approved by the federal Food and Drug Administration (FDA) for
16 the treatment of substance use disorders on the lowest tier of the
17 drug formulary developed and maintained by the health care service
18 plan, and shall not do any of the following:

19 (a) Impose any prior authorization requirements on any
20 prescription medication approved by FDA for the treatment of
21 substance use disorders.

22 (b) Impose any step therapy requirements before authorizing
23 coverage for a prescription medication approved by the FDA for
24 the treatment of substance use disorders.

25 (c) Exclude coverage for any prescription medication approved
26 by the FDA for the treatment of substance use disorders and any
27 associated counseling or wraparound services on the grounds that
28 those medications and services were court ordered.

29 SEC. 3. Section 10144.41 is added to the Insurance Code, to
30 read:

31 10144.41. (a) A health insurer shall submit an annual report
32 to the department on or before March 1 of each year certifying
33 compliance with Sections 10144.4, 10144.42, and 10144.5, and
34 the federal Paul Wellstone and Pete Domenici Mental Health Parity
35 and Addiction Equity Act of 2008 (Public Law 110-343), hereafter
36 referred to as the MHPAEA, its implementing regulations, and all
37 related federal guidance. The department shall make the report
38 available upon request and shall post the report on the department’s
39 Internet Web site.

1 (b) A health insurer shall include, but not be limited to, all of
2 the following information in the annual report required pursuant
3 to subdivision (a):

4 (1) A description of the process used to develop or select the
5 medical necessity criteria for mental health and substance use
6 disorder benefits and the process used to develop or select the
7 medical necessity criteria for medical and surgical benefits.

8 (2) Identification of all nonquantitative treatment limitations
9 (NQTLs) that are applied to both mental health and substance use
10 disorder benefits and medical and surgical benefits within each
11 classification of benefits.

12 (3) The results of an analysis that demonstrates that for the
13 medical necessity criteria described in paragraph (1) and for each
14 NQTL identified in paragraph (2), as written and in operation, the
15 processes, strategies, evidentiary standards, or other factors used
16 in applying the medical necessity criteria and each NQTL to mental
17 health and substance use disorder benefits within each classification
18 of benefits are comparable to, and are applied no more stringently
19 than, the processes, strategies, evidentiary standards, or other
20 factors used in applying the medical necessity criteria and each
21 NQTL to medical and surgical benefits within the corresponding
22 classification of benefits. At a minimum, the results of the analysis
23 shall do all of the following:

24 (A) Identify the factors used to determine that an NQTL will
25 apply to a benefit, including factors that were considered, but
26 rejected.

27 (B) Identify and define the specific evidentiary standards used
28 to define the factors and any other evidence relied upon in
29 designing each NQTL.

30 (C) Provide the comparative analyses, including the results of
31 the analyses performed to determine that the processes and
32 strategies used to design each NQTL, as written, and the written
33 processes and strategies used to apply the NQTL to mental health
34 and substance use disorder benefits are comparable to, and are
35 applied no more stringently than, the processes and strategies used
36 to design each NQTL, as written, and the written processes and
37 strategies used to apply the NQTL to medical and surgical benefits.

38 (D) Provide the comparative analyses, including the results of
39 the analyses performed to determine that the processes and
40 strategies used to apply each NQTL, in operation, for mental health

1 and substance use disorder benefits are comparable to, and are
2 applied no more stringently than, the processes or strategies used
3 to apply each NQTL, in operation, for medical and surgical
4 benefits.

5 (E) Disclose the specific findings and conclusions reached by
6 the health insurance policy that the results of the analyses described
7 in this paragraph indicate that the health insurance policy is in
8 compliance with the MHPAEA, its implementing regulations, and
9 all related federal guidance.

10 (c) A report submitted to the department pursuant to this section
11 shall not include any information that may individually identify
12 insureds, including, but not limited to, medical record numbers,
13 names, and addresses.

14 (d) The department shall review the reports submitted by health
15 insurers pursuant to subdivision (a) to ensure compliance with this
16 section, Sections 10144.4, 10144.42, 10144.5, and the MHPAEA,
17 its implementing regulations, and all related federal guidance. The
18 results of the review shall be made available upon request and
19 shall be posted on the department’s Internet Web site.

20 (e) (1) The department shall annually report to the Legislature
21 the information obtained through the reports and the results of the
22 review of the reports, and on all other activities taken to enforce
23 this section, Sections 10144.4, 10144.42, and 10144.5, and the
24 MHPAEA, its implementing regulations, and all related federal
25 guidance.

26 (2) The California State Auditor shall review the department’s
27 implementation of this section, and shall report its findings from
28 the review to the Legislature.

29 (3) A report submitted pursuant to this subdivision shall be
30 submitted in accordance with Section 9795 of the Government
31 Code.

32 (f) For purposes of this section, “nonquantitative treatment
33 limitations” or “NQTL” means those limitations described in the
34 implementing regulations of the MHPAEA.

35 SEC. 4. Section 10144.42 is added to the Insurance Code, to
36 read:

37 10144.42. Notwithstanding any other law, a health insurer that
38 provides prescription drug benefits for the treatment of substance
39 use disorders shall place all prescription medications approved by
40 the federal Food and Drug Administration (FDA) for the treatment

1 of substance use disorders on the lowest tier of the drug formulary
2 developed and maintained by the health insurer, and shall not do
3 any of the following:

4 (a) Impose any prior authorization requirements on any
5 prescription medication approved by FDA for the treatment of
6 substance use disorders.

7 (b) Impose any step therapy requirements before authorizing
8 coverage for a prescription medication approved by the FDA for
9 the treatment of substance use disorders.

10 (c) Exclude coverage for any prescription medication approved
11 by the FDA for the treatment of substance use disorders and any
12 associated counseling or wraparound services on the grounds that
13 those medications and services were court ordered.

14 SEC. 5. No reimbursement is required by this act pursuant to
15 Section 6 of Article XIII B of the California Constitution because
16 the only costs that may be incurred by a local agency or school
17 district will be incurred because this act creates a new crime or
18 infraction, eliminates a crime or infraction, or changes the penalty
19 for a crime or infraction, within the meaning of Section 17556 of
20 the Government Code, or changes the definition of a crime within
21 the meaning of Section 6 of Article XIII B of the California
22 Constitution.

Introduced by Senator BeallDecember 3, 2018

An act relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 12, as introduced, Beall. Mental health services: youth.

Existing law, the Children's Mental Health Services Act, establishes an interagency system of care for the delivery of mental health services to seriously emotionally and behaviorally disturbed children and their families.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs.

Existing law authorizes the act to be amended by a $\frac{2}{3}$ vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote.

This bill would declare the intent of the Legislature to enact legislation that would authorize the state and local governments to establish a series of at least 100 centers statewide to address the mental health needs of California youth. The bill would declare the intent of the Legislature to enact legislation to allocate or encourage the allocation of funding for that purpose, as specified. The bill would make related findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. (a) The Legislature finds and declares all of the
2 following:

3 (1) Adolescence and young adulthood, from 12 to 25 years of
4 age, comprise a critical developmental period in a person’s life.
5 The brain is highly malleable, so forming healthy habits of mind
6 and body can have a powerful, lifelong impact on the overall
7 wellness of each child. Recent research demonstrates how
8 especially important it is to establish this foundation during
9 adolescence and young adulthood.

10 (A) One-half of adolescents meet the criteria for a mental
11 disorder at some point in their lives.

12 (B) Seventy-nine percent of youth and young adults with mental
13 health issues do not access care.

14 (C) Seventeen percent of students seriously considered
15 attempting suicide in prior years.

16 (D) Twenty percent of youth abuse alcohol on a monthly basis.

17 (E) Rates of youth marijuana use have reached the highest levels
18 in history.

19 (2) Further complicating the critical mental health service crisis
20 for young people is the reality that most adolescents and young
21 adults are reluctant to seek help, for a variety of reasons, including,
22 but not limited to, the following:

23 (A) Lack of awareness and understanding of mental illness.

24 (B) Stigma associated with mental illness.

25 (C) Lack of age-appropriate, youth-friendly mental health
26 services.

27 (D) Concerns about confidentiality and embarrassment in
28 disclosing mental health concerns.

29 (E) Doubts about the effectiveness of the treatment available.

30 (F) Lack of affordable services and inadequate transportation
31 to service locations.

32 (3) Accordingly, a headspace model will be established and
33 funded in this state that will approach youth wellness in an
34 innovative, comprehensive, and youth-friendly way, reaching
35 adolescents and young adults in clinical sites, and ultimately online
36 and in schools. The core components of the model will include,
37 but not be limited to, the following:

1 (A) A focus on mild to moderate mental health issues, including
2 anxiety and depression.

3 (B) A one-stop site for access to integrated care services,
4 including mental health, physical health, substance use, and
5 educational or vocational support.

6 (C) Accessibility, such that the services will be affordable,
7 destigmatized, appealing to youth, and confidential pursuant to
8 existing state and federal laws.

9 (4) (A) The staff of these centers will be made up of
10 psychiatrists, psychologists, physicians, substance use treatment
11 counselors, and others to provide culturally and linguistically
12 inclusive mental health services to all youth, regardless of insurance
13 status, and no child will be turned away.

14 (B) These centers should provide a special focus on vulnerable
15 and marginalized young people, including LGBTQ, homeless, and
16 indigenous youth.

17 (5) In Australia, a network of 100 mental health centers serves
18 355,000 people throughout the country, each one with its own
19 personality.

20 (b) Therefore, it is the intent of the Legislature to enact
21 legislation that would authorize the state and local governments
22 to establish a series of at least 100 centers statewide to address the
23 unmet mental health needs of California youth through a
24 collaborative process of knowledge sharing and funding.

25 (c) It is further the intent of the Legislature to enact legislation
26 to allocate or encourage the allocation of funding pursuant to
27 county Mental Health Services Act (MHSA) funds or by the Mental
28 Health Services Oversight and Accountability Commission, county
29 behavioral health services departments, and relevant stakeholders
30 to provide technical assistance to entities that will establish a
31 headspace model.

ASSEMBLY BILL

No. 46

Introduced by Assembly Member Carrillo

December 3, 2018

An act relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 46, as introduced, Carrillo. Individuals with mental illness: change of term.

Existing law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions.

This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, “insane” and “mentally defective,” with more culturally sensitive terms when referring to individuals with mental illness.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. It is the intent of the Legislature to enact
- 2 legislation to replace derogatory terms, including, but not limited
- 3 to, “insane” and “mentally defective,” with more culturally
- 4 sensitive terms when referring to individuals with mental illness.

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AGENDA ITEM 8

Action

January 24, 2018 Commission Meeting

Documentary Funding Proposal

Summary: The Commission will consider authorizing the Executive Director to enter into contract(s) not to exceed \$300,000 to support a documentary project on mental health.

Background: The Youth Mental Health Crisis documentary will be executive produced by Peabody, Emmy and Columbia DuPont Award-winning filmmaker Ken Burns as a prime-time documentary series on PBS, on more than 350 stations in over 150 U.S. markets and with international distribution. This ground-breaking multi-media series and multi-year initiative will tackle issues ranging from anxiety, depression, bipolar disorder, schizophrenia, ADHD, addiction, suicide and more.

WETA is a major producing station for PBS, and for more than 30 years, WETA has proudly partnered with Ken Burns to bring breakthrough documentaries to public audiences around the nation. WETA plays an important role in bringing these films to a viewing audience nationwide, and Ken Burns and his colleagues at Florentine Films are working with WETA on this new documentary project around brain health and mental health.

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Tom Chiodo, Executive Producer, Special Projects, WETA
- Lisa Paulsen, Consultant, WETA; Co-Founder, Stand Up To Cancer

Enclosures (2): (1) Presenter Biographies; (2) Youth Mental Health Crisis Outline

Handouts: None

Proposed Motion: The Commission authorizes the Executive Director to enter into contract(s) not to exceed \$300,000 to support the Youth Mental Health Crisis documentary project.



Tom Chiodo

Executive Producer, Special Projects, National Program Development

WETA, Washington, DC - the leading public broadcasting station in the nation's capital, developing programming for 354 PBS stations in more than 150 markets throughout the U.S.

Recent projects include DuPont Columbia Award winning / Emmy nominated documentary series *Ken Burns Presents Cancer: The Emperor of All Maladies*

(2015) and *Rethinking High School with Soledad O'Brien - A Town Hall at Howard University / XQ Super Schools Project* (2016). Documentaries in development/production: *The Youth Mental Health Crisis, The Gene: An Intimate History, and LGBTQ in America*, among other projects.

Thirty years' experience in the entertainment industry, media and communications. Formerly SVP business development at Entertainment Industry Foundation - creating programs and raising significant funding for key national initiatives in health care, volunteerism, childhood hunger and education, including Stand Up To Cancer (US & Canada), iParticipate, Rise and Honor, HungerIs.org and ThinkItUp.

Tom has also held senior positions at Rubenstein Communications; Manhattan Repertory Company; U.S. Department of Health and Human Services, Massachusetts State Office for Children & Department of Public Health.

Former clients include numerous documentary projects with PBS and HBO; TIME, Inc.; AMC; Wenner Media; Columbia University Humanities Festival; Major League Baseball; (RED); Al Roker Entertainment, Inc.; The Tony Awards; ABC's Good Morning America; Chances for Children; American Express; and The Apollo Theatre.

Co-author "Home Care for Respirator Dependent Children" in the New England Journal of Medicine. Published playwright. Board memberships have included NYC Professional Performing Arts High School, Heart Gallery NYC. Mentor/Advisor: PBS NewsHour Student Reporting Lab at Venice High School.



Lisa Paulsen

Co-Founder/Executive Producer, Stand Up To Cancer; Consultant, WETA

Lisa Paulsen was President and CEO of the Entertainment Industry Foundation for 27 years before stepping down in 2017 to focus on talent relations, fund development and to serve as executive producer for the biennial multi network telecast, *Stand Up To Cancer*, which she co-founded in 2008 under the EIF umbrella.

During Lisa's tenure as CEO, EIF grew into a prominent leader in the philanthropic community, raising over \$1 billion to address important social, educational, disaster relief and health causes.

Lisa spearheaded programs such as iParticipate, a campaign on over 100 prime time programs created to inspire more Americans to volunteer in their communities, and Hunger Is, which raises funds to support programs to end childhood hunger.

Lisa also served as Executive Producer of XQ:The Super School on all four major networks to promote innovative education programs, and produced the roadblocks "Hope for Haiti Now" with George Clooney, and "Somos Una Voz" with Marc Anthony, Jennifer Lopez and Alex Rodriguez for disaster relief and rebuilding efforts.

Lisa serves on the board of directors for the Academy of Country Music Lifting Lives and has received numerous awards including Hollywood Reporter's 100 Most Powerful Women, Television Academy Honors/Television with a Conscience, and one of the The Nonprofit Times' Power & Influence Top 50, celebrating the nonprofit sector's top executives for five years.

THE YOUTH MENTAL HEALTH CRISIS

Mental health problems are the leading cause of human suffering and will account for over half of the economic burden of all chronic diseases over the next 20 years. It is the healthcare challenge of our time.

1 in 4 individuals will experience mental illness in their lifetime

66% do not receive treatment

Those who do, wait 8 to 10 years due to stigma and lack of access

75% percent of mental illness manifests by the age of 24

**Suicide is the second leading cause of death for young people ages 10 to 24
and the leading cause of death for girls 15 to 19**

Fortunately, advances in neuroscience, technology, and policy, combined with a growing mental health advocacy movement, have set the stage for dramatic change at an inflection point in our society. And now, WETA has begun work on the **first film in a new PBS documentary series and multi-platform initiative** that will focus on **Brain Health / Mental Health**.

The Youth Mental Health Crisis will be executive produced by Peabody, Emmy and Columbia DuPont Award-winning filmmaker **Ken Burns** as a **prime-time documentary series on PBS** on more than **350 stations** in over **150 U.S. markets** and with **international distribution**.

This ground-breaking **multi-media series and multi-year initiative** will tackle issues ranging from anxiety, depression, bipolar disorder, schizophrenia, ADHD, addiction, suicide and more. It will explore the numbers behind the crisis, successful advances in research, diagnosis, therapies, prevention, and collaborations, with personal stories and hope for the future of mental health & brain health, the most complex object of study in the history of science.

We are seeking sponsors to support the production of this important documentary series and the robust initiative we will build around it. The documentary will be accompanied by an **expansive outreach, education, and social media campaign** with a strong focus on **direct engagement of youth and communities** – with **short form content distribution and interactive website**, to **digital streaming, mobile device downloads and apps, celebrity ambassadors, events, screenings, and panel discussions**. Online classrooms and educational modules will be created for teachers and students based on the documentary series with education partners and PBS learning media (with 1.9 million teacher subscribers, reaching 30 million students nationwide).

Presenters:

Tom Chiodo, Executive Producer, Special Projects, National Program Development WETA, a Flagship PBS Station in our Nation's Capital.

Lisa Paulsen, Consultant, WETA; Co-Founder, Stand Up To Cancer

AGENDA ITEM 9

Action

January 24, 2019 Commission Meeting

Innovation Incubator Implementation

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 collaboratives 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 for technical assistance and support to achieve 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. These funds must 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, the Commission was presented with a Business Plan for Commission comment. The plan included three distinct components:

1. **Developing an Innovation Roadmap:** Commission staff has strengthened its process for the 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 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, a clear need was identified for a broader level of technical assistance and a clearinghouse of information and data to support improvement to the mental health system. For example, the Commission provided financial support to the UC Davis Behavioral Health Center of Excellence to launch a multi-county Collaborative on Early Psychosis. Similar efforts are underway on school mental health and integrated behavioral health and physical health for Transition Age Youth. The Commission should consider expanding those opportunities.
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 facilitating multi-county collaboratives, offering technical assistance to counties, providing guidance on evaluation and supporting the dissemination of lessons learned.

In the November Commission Meeting, Staff presented a progress report on planning for the Innovation Incubator. Commissioner Brown raised the issue of sustainability and how the Innovation Incubator would be structured. Commission staff were directed to explore whether the Incubator should be managed by an external entity or managed by the Commission.

In response, Commission staff worked with our consultants to evaluate three options described below:

OPTION A: Build and manage internally.

Under this option, the Commission would need to seek budget authority to expand its staff to operate the Incubator internally. This option would provide the greatest level of control for the Commission

and ensure the Incubator focuses on issues of statewide concern. Assuming full administrative responsibilities would likely delay the launch and impact of the incubator.

OPTION B: Contract with an external organization to build and manage.

The Commission issues a Request for Proposal (RFP) and selects an external contractor to build, manage and sustain the Innovation Incubator. Option B would allow the Incubator to be up and running in six to twelve months and would not significantly impair Commission operations. External management of the Incubator could make it difficult to ensure a focus on statewide concerns and may not be aligned with Commission priorities and requirements for streamlined approval such as a consent process.

OPTION C (Recommended): Manage internally with contractor support.

The Commission would plan, and manage the Innovation Incubator internally and contract out for services specific projects. This option would allow the incubator to focus on statewide concerns, yet allow the effort to contract for the majority of the work

Presenters: Toby Ewing, Ph.D., Executive Director
David Smith, X-Sector Labs

Enclosures (1): Innovation Incubator Implementation Proposal

Proposed Motion: The Commission adopts “Option C: manage internally with contractor support” to implement the development of the Innovation Incubator.

Executive Summary

This document describes the services and functions of the proposed Innovation Incubator, provides an operational plan, budget, and timeline, and, outlines options for how the Commission can organize, manage and launch the Innovation Incubator in the 2018-19 fiscal year.

Ensuring access to 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 an 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 to 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 the number of people served, but sustained reduction of homelessness, incarceration, suicide, and unemployment, and enhanced recovery and well-being.

The Innovation Incubator is designed to help the Commission improve outcomes by supporting the behavioral health system to become more consumer-centric and data-driven, while focusing on community engagement, quality improvement, and capacity building.

The objective of the initial phase for the Innovation Incubator will be to help the county behavioral health departments design strategies, services, and programs that reduce the number of people who are deemed incompetent to stand trial (IST). It will accomplish this by helping counties develop and implement innovation plans, and it will actively support counties to develop the capacity to experiment, learn, and deploy new practices.

The initial phase of the Innovation Incubator is proposed to last two or three years and will pilot effective innovation processes. The incubator will identify multiple “Design Challenges” and provide technical assistance to county-led collaboratives seeking to meet those challenges in more effective ways than the existing system. One result of these challenges will be more refined proposals to the Commission for how counties will spend their innovation funds, including through multi-county collaboratives.

The Incubator is supposed to have seven key functions:

- Function 1: Community Need Sourcing
- Function 2: Designing and Building Solutions
- Function 3: Innovation Funding Approval

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- Function 4: Technical Assistance for Implementation
- Function 5: Quality Improvement and Evaluation
- Function 6: Policy Advocacy
- Function 7: Sharing Best Practices

The Incubator is supposed to deliver these functions by following these operational steps:

- Hire Team
- Identify Key Consultants
- Conduct Community Need Sourcing
- Launch Design Challenges (Plan to host three challenges over two years)
- Innovation Proposals Approved by Commissioners
- Technical Assistance, Quality Improvement, and Evaluation through Implementation
- Proposed Policy Changes and Disseminating Learnings

Assuming the Commission leadership agrees to these functions and this operational strategy, the key decision is to select the management approach to launch the Incubator. This document outlines three options:

- **OPTION A:** Build and manage the Incubator internally at the Commission
- **OPTION B:** Contract with an external organization to build and manage the Incubator
- **OPTION C:** Manage internally at the Commission with significant contractor support

The criteria the Commission should consider involve system-level outcomes. Which option is most likely to:

- Effectively help all counties conceive and deploy better innovation plans
- Effectively provide technical, social, and political support to pioneering counties
- Effectively address the legislatively directed goal of reducing the number of consumers deemed Incompetent to Stand Trial , with the additional benefit of demonstrating to policymakers and counties the potential of innovation

Additional considerations include:

- **Control** – How important will it be for the Commission to control strategic and operational aspects of the Incubator and integrate with other organizational priorities?
- **Risk** – Which option enables the Commission to manage the risks to government agencies that try to change practices and to nurture a culture at the state and county levels that accepts experimental failures as learning opportunities necessary for innovation?
- **Procurement** – Which structure will allow for funds to be encumbered on a schedule consistent with state budget cycles (\$2,500,000 in FY18-19 and \$2,500,000 in FY19-20)?
- **Sustainability** – Which structure provides the greatest opportunity for the Incubator to generate enough value and support to be sustained beyond the initial state investment?

Recognizing these considerations, the recommendation for the Commission is Option C – to internally manage the launch of the Innovation Incubator with significant contractor support.

Innovation Incubator Goals and Functions

Creating an Innovation Incubator would enable behavioral health departments to more effectively and efficiently innovate to address the evolving needs of the communities served. At a high level, it would do so by engaging human-centered design experts and associated practices across sectors in the incubation process to build internal innovation capacity for counties, while also facilitating connections and communications within county collaborations and across the state.

The goal of this initial phase for the Innovation Incubator will be to help the county behavioral health departments design products, services, and programs aimed at reducing the number of people who are deemed incompetent to stand trial (IST). The county behavioral health departments are tasked with addressing challenges stemming from those who are IST, and as the incidence and impact rises, the counties need new, creative solutions to address the issue.

IST is the first challenge but not the only goal of the Innovation Incubator. Over time, the Incubator will support the development of new strategies and services using innovation funding. It will accomplish this by helping counties design innovation plans for consideration by the Commission, and it will actively engage and support counties to develop the capacity to experiment, learn and deploy new practices across additional issue areas.

The initial phase of the Innovation Incubator is proposed to last 2-3 years to pilot effective innovation processes and build capacity for counties by providing two key services:

Design Challenges: The Innovation Incubator publishes a specific “challenge” based on statewide behavioral health needs. If county-level collaborations are aiming to address similar challenges, they can participate in a design competition by expressing interest in joining a cohort of counties interested in prototyping solutions. The challenges serve to invite a broader array of perspectives and approaches to solution development while creating a group of stakeholder interested in sharing learnings and collaboration.

Technical Assistance: External innovation experts provide support, training, and consulting services to counties engaged in these challenges to improve the effectiveness and efficiency of their innovation processes with a goal of building internal capacity to lead these efforts in the future. This proposal focused on technical assistance specifically for county-led collaborations focused on reducing people deemed IST. Future phases could provide similar technical assistance and capacity building to a broader audience.

The Incubator will have seven key functions:

Function 1: Community Need Sourcing – The Incubator will conduct in-the-field research with an array of stakeholders across counties to immerse themselves in the lives of the people they are serving in order to deeply understand their needs. This experience helps to more clearly

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define the root causes of the IST issue from multiple perspectives. The result of this phase is a problem statement appropriately targeted at the root causes of the issue. These problem statements will be used to establish the Incubator's *Design Challenges*.

- Interviewers will be trained in conducting empathy interviews, a cornerstone of human-centered design, which involve understanding how different stakeholders experience the problem being addressed and ideas for how the problems might be addressed differently.
- Interviewees will include diverse stakeholders who are impacted by the IST issue. This will provide a thorough understanding of the unique perspectives and challenges faced by those directly and indirectly impacted. The interviewees will include, but are not limited to, those who were previously deemed IST, family members, behavioral health service providers, local and statewide stakeholder groups, and nonprofit and government professionals within the justice system and behavioral health system.
- Those conducting the interviews will periodically meet to discuss findings and identify trends across the data they have captured along with research conducted by other Commission initiatives. Being exhaustive and thorough in this stage of the process is critical, as these insights will serve as the backbone for the rest of the innovation process.
- One specific need, or a group of related needs, will be designed for at a time. Attempting to address too large, or too complex of a solution at a time will lead to inefficient or ineffective solutions.
- Through the series of interviews and human-centered design labs, the Innovation Incubator will collect enough data to identify the top three root causes worthy of deeper exploration. These root causes will form the thesis problem statements for the Design Challenges that the Incubator will facilitate over the following 24 months.
- *Similar example from a previous Commission engagement:*
 - *The Commission Schools and Mental Health Project: a Commission-led initiative focused on building a shared understanding of the barriers, challenges, and opportunities surrounding unmet or inadequately met mental health needs in California's children. Through this project, the Commission is identifying actionable recommendations for strategies and solutions, including those in the realm of the Commission's tools—PEI, Innovation, Triage, Plan Review, Research and Evaluation, and supporting legislation.*

Function 2: Designing and Building Solutions – The Incubator will co-create and design solutions to address the root causes of the specific IST issue identified during the community need sourcing process. This second function phase will identify solutions to prototype and refine through field testing. The Incubator will facilitate connections between counties and organizations with similar needs so they can partner in designing solutions and submitting proposals for innovation funds, and it will help counties find partners that can address their capacity or skill-based gaps in building their solutions. This phase will include prototyping and testing solutions through a human-centered design approach prior to submitting proposals for innovation funds.

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- The human-centered design process is quick and dynamic, involving a continued cycle of designing, iterating, testing solutions in the field with real consumers, and repeating that process until a solution is identified that demonstrates its ability to effectively and sustainably solve the root cause of the problem identified in the need sourcing process.
- Stakeholders across the populations impacted by the issue will be engaged in both the design and testing processes in order to ensure community-buy in. The emphasis of this stage is designing solutions that will be sustainable and accepted within the communities that are seeking impact.
- Counties who have identified a need will work with the Incubator to submit a proposal that outlines the specific need they're interested in designing solutions around. Entities with similar needs can opt-in to participate in the design and proposal process, thus forming a *Community of Practice* as part of a *Design Challenge*.
- The Incubator will help form *Communities of Practice* by matching counties (and a subset of their local cross-sector stakeholders) with other county collaboratives with shared interests and fostering ongoing communications, increasing the opportunity for shared learning and partnerships.
- By forming these partnerships, it can increase the scale, as well as efficiency of the solutions that are designed, ensuring that the solutions reach more people, are more comprehensive by including a broader array of stakeholders, and use significantly fewer resources by pooling the design-thinking and proposal submission process.
- The Incubator will help counties (through the *Communities of Practice*) identify the right strategic partners to ensure that the solutions proposed for innovation funding are both effective and feasible. For example, if a county identifies a solution that involves building an app, the Incubator could facilitate a connection with a tech company that could help design and deliver said solution, and perhaps scale use into multiple counties throughout the state.
- By facilitating these partnerships, the funding proposals become much more concrete and comprehensive, thus increasing the likelihood they not only get approved sooner, but also that they deliver the desired impact.
- *Similar examples from a previous Commission engagement:*
 - *San Diego Innovation Project's BeHealth.Today: April 2018, San Diego County had requested authorization to use \$100,000 of Innovation funds for community planning process to guide an Innovation project. The county is using a human-centered design strategy in the BeHealth.Today project.*
 - *Head Space Innovation Project: In November 2017 meeting, the Commission authorized Santa Clara County approximately \$572,000 in Innovation funding to support a planning phase for its Head Space Innovation Project.*
 - *The Early Psychosis INN Proposal: After UC Davis found there was a lack of standardization and infrastructure to adequately evaluate the effectiveness of the Mental Health Service Act funded or other publicly funded EP programs in California, the Commission contracted with them to develop a proposal to identify potential county providers to deliver a solution.*

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Function 3: Innovation Funding Approval – The Incubator will consult with counties on how to effectively and efficiently move innovation plans through the Commission review and approval process.

- The Incubator will have a close partnership with the Commission to ensure they're well-versed in the requirements and stages of the innovation process the Commission has for approving innovation funding. These requirements will result in clearly defined criteria for advising counties on how to successfully apply for funding and to ensure that solutions are effectively addressing the need they're designed to address.
- Throughout the process, the Incubator will provide guidance and technical assistance support to the *Communities of Practice*. This will help counties efficiently navigate the innovation funding process while also assuring Commissioners that the proposals have been appropriately vetted and supported. This will allow for expedited approval.

Function 4: Technical Assistance for Implementation – The Incubator will provide ongoing technical assistance for county-led collaboratives as they begin to implement their innovative solutions approved by the Commission.

- The Incubator will continue to provide guidance and technical assistance support to the *Communities of Practice* as they implement the solutions approved by the Commission. This will ensure counties have the capacity and skill set to effectively launch their innovative solutions.
- A fixed level of support in the areas of community and stakeholder engagement, human-centered design, and multi-stakeholder collaboration will be provided by the Incubator with the intent of building internal capacity within the county-led collaborations. If additional support is needed over the life cycle of the intervention, technical assistance resources could be included in the budget request for innovation funds.

Function 5: Quality Improvement and Evaluation – The Incubator will monitor the implementation and success of the innovations using objective metrics to ensure that solutions are effectively addressing the need they're designed to address.

- The Incubator will work alongside the counties to identify objective metrics for success throughout the process of implementation, delivery and scale. It will also develop a mechanism to regularly collect and track these metrics to identify how well the innovation is doing at addressing the problem, and how it can be improved.
- This support will include short-term quality indicators to increase efficiency and effectiveness of the innovation and collaboration process itself, as well as long-term outcome metrics focused on the desired population and broader impact.
- It is assumed that each proposal for innovation funding will also include budgeted resources for quality improvement and evaluation beyond the Incubator support. However, the Incubator evaluation and learning team will work closely with the project evaluation teams to capture learnings across all the innovative solutions launched through all of the Design Challenges.

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Function 6: Policy Advocacy – The Incubator will work with the Commission and other government agencies to improve systems to support effective innovations.

- Innovative solutions often involve processes and practices outside the realm of existing statutes and regulations and may require new policies and programs to support their success throughout the design and implementation process.
- Innovations can illuminate unintended barriers and restrictions within the current systems that require policy change to remove or reduce these impediments.
- The Incubator will work with counties and relevant stakeholders to implement the necessary policy or support mechanisms for innovations that make appropriate changes.

Function 7: Sharing Best Practices – The Incubator will disseminate insights and proven best practices from successful and failed innovation efforts across counties.

- The Incubator will continually evaluate the outcomes from the metrics-based evaluations in order to identify trends in what make successful and unsuccessful innovations for improving outcomes.
- Insights will be shared across counties in order to improve innovation processes, as well as provide promising solutions that can be introduced into additional counties to address similar challenges, creating more learnings and desired outcomes.
- For counties that are interested in implementing similar programs or practices within their communities, the Incubator can also consult with them in how to design and tailor the solution for their unique needs and circumstances.
- *Similar example from a previous Commission engagement:*
 - *Evaluation of the Community Program Planning Process: MHSOAC contracted with Resource Development Associates, who worked with a peer advocacy organization, to conduct an evaluation of local community program planning processes. The evaluation resulted in a series of community-based training sessions by an organization funded through an MHSOAC stakeholder advocacy contract.*

Innovation Incubator Operational Plan

There are three options outlined below for how the Incubator could be structured and managed. All three of them will require the development of a staffing team that will then follow a process to achieve the goals and fulfill the seven functions outlined above. Here are the key operational steps to consider:

A) Hire Team

- 1) Executive Director** – an executive with experience building incubators and fostering innovation processes. Responsibilities include: strategy, vision, fiscal oversight, business plan, establishing and managing key external partnerships, program sustainability, and delivering desired impact.
- 2) Deputy Director** – an executive with internal operations and management experience. Responsibilities include: building a high performing team, ensuring superb operations, setting a culture of learning, and helping staff achieve potential.
- 3) Learning and Evaluation Manager** – a manager with experience building a learning or data-driven organization through quality improvement and evaluation. Responsibilities include: creating a culture of learning, establishing key performance indicators, collecting data, sharing best practices, and selecting, managing, and supporting the contractors necessary to achieve the Incubator’s goals.
- 4) Design Challenge Manager** – a manager with experience building communities of practice and cohorts focused on innovation and learning. Responsibilities include: supporting the design and delivery of the design challenge process, fostering an active community of practice, and selecting, managing, and supporting the contractors necessary to achieve the Incubator’s goals.
- 5) Technical Assistance Manager** – a manager with innovation expertise and contracting experience, ideally between governments and external entities. Responsibilities include: selecting, managing, and supporting the technical assistance contractors necessary to achieve the Incubator’s goals.
- 6) Executive Assistant** – an assistant with administrative and operations experience. Responsibilities include: supporting both the Director and Deputy Director as well as operations support for the full team.

B) Identify Key Consultants

1) Learning and Evaluation Specialist

The Learning and Evaluation Contractor would provide technical assistance support for the Innovation Incubator as well as each of the proposals supported through the Design Challenges. These services will include expert consultants to design and deliver a learning strategy for the Incubator, including creating a culture of learning, establishing key performance indicators, collecting data, and sharing best practices.

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2) **Design Challenge Specialist**

The Design Challenge Contractor will provide program and operations support for the Innovation Incubator for each of the Design Challenges. These services include: building communities of practice, faculty time for design and facilitation, coordinating participant travel, in-person events, virtual engagement, and recruiting experienced Senior Fellows for each Incubator participant.

3) **Technical Assistance Specialist**

Experienced contractors with an expertise in community and stakeholder engagement and human-centered design will help design and deliver support for the early phases of the Innovation Incubator – including supporting the initial need sourcing and problem statement definitions for each design challenge. These contractors will also provide support for each of the design projects (as needed).

Additionally, experienced contractors with an expertise in multi-stakeholder collaboration, quality improvement, evaluation, and research will be engaged to provide support for each of the design projects (as needed).

C) **Conduct Community Need Sourcing (Incubator function 1)**

The Innovation Incubator staff will collaborate with the Technical Assistant Contractors skilled in community and stakeholder engagement as well as human-centered design, to conduct a statewide engagement process to discover the root causes for the IST challenge. Through the series of interviews as well as HCD design labs, the Innovation Incubator will collect enough data to identify the top three root causes worthy of deeper exploration. These root causes will form the thesis problem statements for the three Design Challenges that the Incubator will facilitate over the following 24 months.

D) ***Launch Design Challenge #1 (Incubator function 2)***

Each Design Challenge will have a similar structure, including:

- 1) **Problem Statement** – established through the need sourcing process
- 2) **Application Process** – call for applications from local collaborators focused on building solutions related to the problem statement
- 3) **Community of Practice Selection Process** – criteria for selection into each Community of Practice will be set in advance to ensure alignment with problem statement, shared needs, geographic and demographic diversity, and cross-sector partnerships, but each community of practice will be limited to 5-6 counties
- 4) **Community of Practice** – each county selected to participate will be allotted 4-5 seats within the Community of Practice (representatives of each of the key organizations supporting the cross-sector collaborative), and the full 24-25 participants will meet on the following schedule:

The entire Design Challenge process will occur over six months with each member of the Community of Practice committing the equivalent of eight workdays of time to participate in this effort, including:

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- Design Lab Retreats – three 2-day sessions in-person (month 1, 3 and 6)
- Virtual Meetings – eight 2-hour sessions via video (throughout process)
- Following the initial six months of the Design Challenge, the Community of Practice will be reconvened for single day learning sessions 12, 18, and 24 months after their Design Challenge has concluded

5) Technical Assistance and Design Support – each participating cross-sector collaborative will be provided support based on their needs, including:

- *Senior Fellow* – each participating county collaborative will be paired with an experienced leader (ideally respected former behavioral health directors)
- Expert consultant support in the areas of:
 - Community and Stakeholder Engagement
 - Human Centered Design
 - Multi-Stakeholder Collaboration
 - Quality Improvement and Evaluation

6) Final Product – each Community of Practice will yield 1-2 proposals for innovation funding with a goal of each proposal defining a partnership between 2-5 counties

E) Innovation Proposals Approved by Commissioners (*Incubator function 3*)

Following the Design Challenge, proposals for innovation funding will move to the Commission for approval, and these proposals should meet the innovation criteria set forth by the Commission and therefore pass on the Commission's consent calendar.

F) Design Challenges #2 and #3 and Innovation Proposals Approved by Commissioners

The Innovation Incubator will run three Design Challenges over the first two years. Each Design Challenge will last approximately six months, with the subsequent Design Challenge and Community of Practice being convened following the conclusion of the former.

G) Provide Technical Assistance for Implementation (*Incubator function 4*)

Technical assistance consulting will be provided to each collaborative project going through the Design Challenge in the areas of community and stakeholder engagement, human-centered design, and multi-stakeholder collaboration. This is intended to help county-led collaborations effectively launch their innovation projects, but the consulting will focus on building internal capacity by teaching these skills through practice.

H) Quality Improvement and Evaluation through Implementation (*Incubator function 5*)

Quality improvement and evaluation consulting will be provided to each collaborative project going through the Design Challenge as part of the technical assistance. This will initially include design and metric support, and any ongoing evaluation costs will be included in the innovation fund proposal. Some quality improvement and continuous learning support will be provided for each collaborative project and the Community of

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Practice itself. The Community of Practice will be reconvened three times beyond the Design Challenge strictly to mine lessons learned, share failures and best practices, and improve the quality of the Innovation Incubator offerings with each iteration. It is assumed that each proposal for innovation funding will also include budgeted resources for quality improvement and evaluation beyond the Incubator support. However, the Incubator evaluation and learning team will work closely with the project evaluation teams to capture learnings across all the innovative solutions launched through all of the Design Challenges.

I) Proposed Policy Changes and Disseminating Learnings (*Incubator functions 6-7*)

Through the learning cycle taking place within each Community of Practice, the Innovation Incubator will work with the Commission and policy makers to improve systems to support effective innovations. This will include reducing administrative barriers and proposing new authorities to support the success of innovative processes and increase their intended impact. The Incubator will produce interim reports on key learnings and policy recommendations following each Design challenge, and it will issue a final report at the conclusion of the evaluation period following the third Design Challenge. The final report will include lessons learned through the innovation process and the evaluation teams of each the solutions implemented to reduce those deemed IST.

The Innovation Incubator will work closely with the Learning Community, the Commission, and key statewide knowledge sharing networks to disseminate insights and proven best practices from successful and failed innovation programs across counties. This will also include providing opportunities to expand promising innovations to additional counties through an expedited approval process set forth by the Commission.

Draft Innovation Incubator Budget

The state budget authorized \$5,000,000 over two fiscal years (FY18-19 and FY19-20)

A) Startup Consultant Costs (\$200,000)

B) Hire Team (\$1,500,000 for six full-time employees)

1. Executive Director (\$375,000: \$150k/year for 2.5 years)
2. Deputy Director (\$250,000: \$100k/year for 2.5 years)
3. Learning and Evaluation Manager (\$400,000: \$100k/year for 4 years)
4. Design Challenge Manager (\$200,000: \$100k/year for 2 years)
5. Technical Assistance Manager (\$150,000: \$75k/year for 2 years)
6. Executive Assistant (\$125,000: \$50k/year for 2.5 years)

C) Identify Key Consultants (\$3,300,000)

- Learning and Evaluation Contractor (\$500,000: \$200k upfront plus \$100k/challenge)
 - \$200k for Incubator's learning and evaluation plus \$100k/challenge
- Design Challenge Contractor (\$1,150,000: \$350k/challenge)
 - Design Challenge Faculty and Facilitators: \$100k upfront plus \$100k/challenge
 - Travel, Event Costs, and Operations Support: \$100k/challenge
 - Senior Fellows (5 @ \$20k each): \$100k/challenge
 - Reconvening at 12, 18, and 24 months: \$50k/challenge
- Technical Assistance Contractors (\$1,650,000: \$300k upfront plus \$450k/challenge)
 - Community/Stakeholder Engagement
 - Incubator's Need Sourcing: \$150k
 - Supporting Community of Practice: \$150k/ challenge (split between support during the Design Challenge and during implementation phase)
 - Human-Centered Design Facilitation
 - Incubator's Problem Statement Definition: \$150k
 - Supporting Community of Practice: \$150k/challenge (split between support during the Design Challenge and during implementation phase)
 - Multi-stakeholder Collaboration
 - Supporting Community of Practice: \$150k/challenge (split between support during the Design Challenge and during implementation phase)

Innovation Incubator Criteria to Consider

The criteria the Commission should consider involve system-level outcomes.

Which option is most likely to:

- Effectively help all counties conceive and deploy better innovation plans
- Effectively provide technical, social, and political support to pioneering counties
- Effectively address the legislatively directed goal of reducing the IST population, with the additional benefit of demonstrating to policymakers and counties the potential of innovation

Additional considerations include:

- **Control** – How important will it be for the Commission to control strategic and operational aspects of the Incubator and integrate with other organizational priorities? Greater control will allow for increased alignment with other organizational goals, sharing of continuous learning throughout the organization, and ability to pivot or adjust priorities and focus throughout the lifecycle of the Incubator.
- **Risk** – Which option enables the Commission to manage the risks to government agencies that try to change practices and to nurture a culture at the state and county levels that accepts experimental failures as learning opportunities necessary for innovation?
- **Procurement** – Which structure will allow for funds to be encumbered on a schedule consistent with state budget cycles (\$2,500,000 in FY18-19 and \$2,500,000 in FY19-20)? Which structure will provide flexibility to spend funds over the timeline necessary to achieve goals? What are the limitations of the budgeted funds (e.g. spent on internal staff, contracted through sole source, contracted through open RFP process)?
- **Sustainability** – Which structure provides the greatest opportunity for the Incubator to generate enough value and support to be sustained beyond the initial state investment? How will earned revenue models be tested within this phase of the project? How will learnings be captured and disseminated beyond the two years of funding?

Innovation Incubator Management Options

The Commissioners should evaluate the following three options considering the criteria above:

OPTION A: Build and manage internally at the Commission

The Commission follows the operational plan to build and manage the Innovation Incubator internally by recruiting the necessary talent and hiring employees to run the Incubator. Beyond the internal staff, contractors will be leveraged to fulfill the learning and evaluation, design challenge, and technical assistance services. This option would provide the greatest level of control for the Commission, and allow the Incubator to focus on issues of shared county and statewide concerns

Considerations

- Primary advantages of this option include:
 - High level of control and direction: Managing the Incubator internally will enable the Commission to adjust the direction and nature of the Incubator as new information, learning and circumstances arise that could impact the work of the Incubator. By fostering a dynamic program, the Commission can ensure the Incubator is constantly aligned with the goals, incentives and missions of the Commission and counties at large.
 - Long-term consistency: Internal management and development of internal resources to support the Incubator ensures that the Incubator, and any learnings and processes that are developed, are sustained beyond the two or three-year contract. This encourages continued process learning and efficiencies.
- Primary disadvantages of this option include:
 - Resource-heavy: the Commission will need to manage (and learn how to manage) each discrete stage in the process and the associated human resource and process requirements each stage dictates. Given the complexity of running an Incubator process, this would require a significant investment in resources. It will be critical these resources remain focused and dedicated to the Incubator and not re-allocated to other priorities.
 - Inexperienced management of Incubator: The skills and knowledge that are required to run an Incubator are fundamentally different than those required by current workstreams, therefore there will be a significant learning curve to understand how to efficiently and effectively run the Incubator. As a result, it also requires talent from different backgrounds, potentially giving rise to mismatches in cultural fit and expectations that can inhibit workflows.
 - May move slower and not encumber funds within FY18-19: recruiting and onboarding staff takes time and once hired their full annual salary is not encumbered immediately where selecting a qualified contractor could happen more quickly and fully encumber the necessary funds by the end of the fiscal year.

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OPTION B: Contract with an external organization to build and manage the Incubator

The Commission would turn the operational plan into a Request for Proposal (RFP) and seeks an external contractor to take on the role of building, managing, and sustaining the Innovation Incubator. This option would be the simplest version for the Commission to implement, yet it would provide the smallest level of control for the Commission as the eventual contractor will be held accountable strictly based on the deliverables outlined in the contracting agreement.

Considerations

- Primary advantages of this option include:
 - Internal resource-light: by contracting the entire Incubator to a third party, the Commission only needs to manage its relationship with one entity, and therefore has little involvement on the day-to-day operations of the Incubator.
 - Experienced management of Incubator: Running an Incubator is a complex process that requires a skill and knowledge-set that is vastly different from current processes within the Commission. By leveraging an entity well-versed in incubation, it ensures the process has the critical resources (human capital and otherwise) to be run efficiently and effectively.
- Primary disadvantages of this option include:
 - Reduced control and direction: By contracting out to a third-party, the Commission loses a high amount of control over how the Incubator is run. Without this control, it's much more difficult to manage any necessary changes in direction, processes, and focus that may arise during the early days of the Incubator. Additionally, it will be more difficult to incorporate any learnings from within the Commission processes into the Incubator workflow.
 - Sustainability of the program: If the external provider chooses not to commit to a continued contract with the Commission (or doesn't identify additional resources or build a sustainable business plan), there could be a disruption of the Incubator process once the contract ends, therefore losing a lot of momentum and learnings generated from the pilot Incubator program.

OPTION C: Manage internally at the Commission with significant contractor support

The Commission follows the operational plan to build and manage the Innovation Incubator internally but hires a limited number of full-time employees and builds additional capacity through contractor support. This option could involve the Commission hiring a single director, manager, and assistant, while adding staff to the key contractor's scope of work. This could move an additional \$1 million into the contractor pool and allow for services to be acquired from subject matter experts and top talent rather than recruiting civil service staff at the Commission. This option would provide a reasonable level of control for the Commission, but would heavily rely on contractors to deliver key functions of the Incubator.

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Considerations

- Primary advantages of this option include:
 - Reasonable level of control and direction: Managing the Incubator internally will enable the Commission to adjust the direction and nature of the Incubator as new information, learning and circumstances arise that could impact the work of the Incubator. Contracts can be written to allow amendments if pivots and redirection is sought by Commission leadership. By being dynamic, the Commission can ensure that the Incubator is constantly aligned with its larger goals, incentives and mission.
 - Long-term consistency: Internal management and development of internal resources to support the Incubator ensures that the Incubator, and any learnings and processes that are developed, are sustained beyond the two or three-year contract. This encourages continued process learning and efficiencies.
 - Ability to hire “best in practice” contractors: When internal resources lack capacity or skills, the Incubator would have the ability to hire specialized contractors, enabling the Commission to select the most skilled contractors in each respective stage of the incubation process.
- Primary disadvantages of this option include:
 - Inexperienced management of Incubator: The skills and knowledge that are required to run an Incubator are fundamentally different than those required by current workstreams, therefore there will be a significant learning curve to understand how to efficiently and effectively run the Incubator (and even select which contractors to hire). As a result, it also requires human resources from different backgrounds, potentially giving rise to mismatches in cultural fit and expectations that can inhibit workflows.
 - Inability to move quickly and encumber funds within FY18-19: recruiting and onboarding staff takes time and once hired their full annual salary is not encumbered immediately whereas selecting a qualified contractor could happen more quickly and fully encumber the necessary funds by the end of the fiscal year.

If this option is selected by the Commission leadership, the recommendation is to follow this structure with regards to internal hiring vs. contracting:

- **Internal Hires**
 - Director: management of Incubator should be done internally, to ensure consistency over the life of the Incubator, as well as alignment around incentives and priorities with the Commission and counties. It will also ensure that any learnings that occur are transferred across entities involved, rather than retained externally. This position could look more like the Deputy Director outlined above as the role will be to serve as team lead, liaison within Commission, and managing the operations of the Incubator.
 - Technical Assistance Manager: given the number of technical assistance consultants that will be hired, it's important to have someone internally that can

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manage workflows to ensure information is communicated efficiently and effectively, as well as objectivity when it comes to monitoring progress and outcomes of respective consultants. In this option, this role would need to expand to also support the imbedded contractors replacing the full-time employees.

- Executive Assistant: with a lean internal team, the Director and Manager will need operations and administrative support to keep all the contractors and Community of Practice participants connected and focused on mission.
- **Consultants**
 - Executive Director: one option could be to hire the Executive Director through an executive-on-loan program as this allows for recruitment of top talent and allows for a fully encumbered salary for the life of this position. A second option could be to eliminate this role and move more resources into the Design Challenge consultant to support building a sustainable business model for the Incubator.
 - Design Challenge Manager: this role could be included in the Design Challenge consultant as an imbedded contractor, allowing one dedicated person to facilitate and manage Design Challenges and ensure consistency across challenges. This would also ensure that any learnings that occur are integrated within future challenges. Design Challenges are complicated processes to run and require resources and skill sets that are outside the bounds of those currently possessed at the Commission. Contracting out to someone well-versed in Design Challenges will ensure this process is run efficiently and effectively.
 - Learning and Evaluation Manager: evaluation outcomes should be done by an objective, external entity to ensure that evaluations are done with as few biases as possible. This role may also last beyond the lifespan of the Incubator (as currently imagined), so a contractor could allow for continued learning and evaluation to be delivered to the Commission by an external entity not directly tied to the Incubator.

Summary and Recommendation

An overarching consideration when determining whether the Innovation Incubator should be built and managed internally by the Commission (Option A) or full contracted out (Option B) is whether the Incubator is intended to evolve based on what is learned or is strictly intended to achieve a specific outcome. If the Commission has a crystal-clear idea of how the Incubator will function and what it will achieve, an RFP could be developed to deliver that exact product and the contractor held responsible for the result. However, if the Incubator is expected to evolve – in structure and process – based on experience and the County and Statewide needs of the Commission and counties, then building and managing internally could be most advantageous.

Through internal control, the risk that innovators take can be managed as the Incubator finds processes, structures, and services that deliver the highest value. This would allow the Incubator's value proposition and earned income strategy would be more mature, increasing the likelihood of sustainability. Subsequently, the Commission would have additional options, such as spinning the Incubator out of the Commission into a new entity with the appropriate governance, seed funding, and relationship with the Commission's innovation plan approval process. Given how new this initiative is, it would be more difficult to fully contract out the Incubator at this time.

While internal control is desired, the capacity and skill set to facilitate an Innovation Incubator is not innate to the Commission. Additionally, if the Commission hires a full internal team, it will be limited to the number of staff and hours to get the entire job done. By contracting, the Commission can purchase a blend of subject matter experts, strategic thinkers, writers, event planners, and logistics experts. This increases the value delivered with the same resources.

For these reasons and those outlined in the considerations section, the recommendation for the Commission is Option C – to internally manage the launch of the Innovation Incubator with significant contractor support.

Note on Innovation Incubator Sustainability

The scope for this document did not include a model for sustainability or earned income strategy. Ultimately, the goal would be to have the Design Challenges create enough value for counties that they would pay to participate in a Community of Practice as innovation funds could be used for planning purposes.

If the Incubator demonstrates its value in the first three Design Challenges, this could be a source of ongoing support and scaling opportunity. Based on this operational plan, the Incubator could be sustained with just \$500,000 to \$1,000,000 per year for core operations. Each Design Challenge would cost \$1,000,000 to \$1,500,000, making the cost per county collaborative would be \$200,000 to \$300,000. These funds could be accessed by those counties submitting proposals to fund a new Design Challenge or potentially the Commission could tap into these funds and create new challenges on priority topic areas.

Additional sources of revenue could include philanthropic and private sector resources to support issue-specific Design Challenges within their funding priorities, and the Incubator could offer technical assistance services to counties and multi-stakeholder collaborations beyond the Design Challenges.

By increasing the number of Design Challenges to 4-5 per year, the annual budget of the Incubator could increase to \$6,000,000 to \$7,500,000 per year. This would allow the Incubator to engage 20-25 counties annually (and nearly 100 community partners). This scenario could be a second phase for the Innovation Incubator as it would likely need to relaunch outside the Commission to fulfill this vision.

AGENDA ITEM 10

Action

January 24, 2019 Commission Meeting

Immigrant/Refugee RFP Outline

Summary: The Commission will consider approval of an outline and authorize the release of a Request for Proposal (RFP) to support advocacy on behalf of immigrants and refugees in California.

Background: California's immigrant and refugee populations face significant mental health challenges as a result of trauma experienced while escaping dangerous conditions in their homeland, traveling to the United States, and then attempting to assimilate into new communities. These challenges have been referred to as the "triple trauma paradigm." Negative mental health outcomes are associated with the traumatic events experienced by immigrants and refugees, including major depression, suicide, anxiety, post-traumatic stress disorder (PTSD), family dysfunction, drug and alcohol dependence, disruptive behavior disorders in youth, as well as increased risks of being targeted for human trafficking.

In response, the Commission in January 2018, directed staff to seek new funding to support stakeholder advocacy on behalf of immigrant and refugee populations. As a result of those efforts, the Governor's 2018 Budget provided \$670,000 annually to the Commission for stakeholder advocacy contracts to increase access to mental health services for immigrants and refugees.

Community Engagement: Consistent with prior stakeholder contract planning and to ensure that community members were included in the process, staff designed an engagement strategy that included dissemination of an information survey, outreach to immigrant and refugee serving agencies, and a series of community listening sessions to hear from members of immigrant and refugee communities as well as cultural brokers and those working with or on behalf of immigrants and refugees.

The Commission released an online survey to determine if there are community organizations able to provide outreach, engagement, training and advocacy on behalf of immigrant and refugee communities. Responses were received from more than 50 organizations across the state working with and on behalf of immigrant and refugee populations from approximately 47 different countries of origin.

Approximately 200 individuals participated at the community listening sessions which were held in counties with high concentrations of immigrants and refugees: Los Angeles, San Diego, Sacramento, and Alameda. These sessions provided an open forum for participants to share information about their experiences and explore the gaps and opportunities for improving access to mental health services among immigrant and refugee communities in California. Participants were asked about barriers to seeking and receiving services and how identified needs could be addressed through training, outreach, and advocacy efforts.

Through these community engagement efforts, participants identified a range of complex challenges addressing barriers to the utilization of mental health services that included issues of cultural competency, availability of appropriate services, linkage and navigation supports, limited resources for community based service providers, fear of deportation and detainment, and distrust of western medical providers and state and county government agencies.

Participants discussed challenges with many complex mental health-related concerns not currently addressed by the existing mental health systems. Those providing services in their communities shared challenges in their work with populations that have experienced numerous stressful events that result in increased rates of anxiety disorders, post-traumatic stress disorder, depression and risk of suicide. Feedback shared from the engagement sessions highlighted the following challenges:

- A need for increased support for a broad range of services including housing, food, school/education resources, medical and dental care, criminal justice navigation, legal and immigration services, job training, and language.
- Lack of capacity of small, grassroots organizations to obtain funding when competing with larger organizations which may not have the experience or expertise necessary to serve the immigrant and refugee populations.
- Lack of materials or mental health services in multiple languages and dialects.
- Lack of information and/or understanding of available mental health services and supports in the community.
- Lack of information and support for understanding how health systems work, eligibility criteria, rights and responsibilities, and how to access and/or navigate services and supports.
- Lack of knowledge on how the unique experiences of immigrants and refugee experiences, including resettlement and adjustment can impact mental health.

- Stigma and discrimination; fear of negative reactions from others in the community because mental illness is often considered a taboo topic.
- Cultural competency challenges, including limited access to quality interpreters, a lack of cultural diversity across service staff and providers, conflicting perceptions about the meaning of mental health, and inability to access preferred traditional supports and practices.
- Challenges accessing care because of eligibility criteria, waiting lists, documentation requirements, inflexible provider hours, transportation and childcare needs, insurance barriers, formality of medical office settings, and a lack of coordinated care between agencies and/or coordination with social services.
- Perceived lack of physical or emotional safe spaces to access care and fear of what might happen if an individual or family members seeks mental health services including risk of deportation, detainment, child welfare involvement, or incarceration.
- Need to strengthen and expand existing community-based organizations to increase capacity to serve as information and assistance hubs, conduct assessments and screening for individuals in safe community spaces, provide a warm hand off and referral support as well as system navigation and personal advocacy support.

To address these challenges, staff recommends allocating funding for up to four immigrant and refugee grassroots organizations. Four contracts will provide approximately \$130,000 per year to support the staff necessary to advocate on behalf of the population served. Funding more than four may not provide for the desired impact to bring needed change. Funding less than four may provide too great a percentage of the organizations yearly budget, leaving them dependent upon the funds in future years.

The Commission is requested to approve the proposed outline of the scope of work for stakeholder contracts for immigrant and refugee populations and to authorize the release of the Request for Proposal (RFP) for the work as outlined.

Enclosures: Recommended Proposed Outline of Request for Proposal (RFP) for Immigrant/Refugee Stakeholder Contracts

Handouts: Power Point presentation will be made available at the Commission meeting.

Presenters:

- Norma Pate, Deputy Director, MHSOAC
- Tom Orrock, Chief, Commission Grants and Operations
- Angela Brand, Contract Lead, Stakeholder Engagement

Proposed Motion:

- The Commission approves the proposed outline of the scope of work for the immigrant and refugee RFP.
- The Commission authorizes the Executive Director to initiate a competitive bid process.

**Recommended Proposed Outline of Request for Proposal (RFP)
for the Immigrant and Refugee Stakeholder Contracts
January 24, 2019 MHSOAC Commission Meeting**

Below is the recommended outline, including minimum qualifications for the Immigrants and Refugees Stakeholder RFP. There will be a total of 4 contracts awarded through this RFP in Year 1. These contracts will be awarded to Local Program Contractors to provide local level advocacy on behalf of immigrant and refugee populations.

In Years 2 and 3 a state-level advocacy contractor will be added to provide for technical assistance and support of the four local, grassroots programs. The state-level advocacy contractor will be selected through a Request for Qualifications (RFQ) process.

Local Program Contractor Funding

The total amount available for each of the 4 local program contracts in Year 1 is \$150,000 per contract for a total not to exceed \$600,000. In Year 2 the total amount available for each of the 4 contractors will be \$130,000 per contract for a total not to exceed \$520,000. In Year 3 the total amount available for each of the 4 contractors will be \$122,500 per contract for a total not to exceed \$490,000.

State-Level Advocacy Contractor Funding

The total amount available for the State-Level Advocacy Contractor in Year 2 and Year 3 is \$200,000 for a two year total of \$400,000.

Outline for the RFP

Contracts will be awarded for each of the following areas:

- Four local, grassroots programs with focus on advocating on behalf of immigrants and refugees.
- One state-level advocacy organization to provide technical assistance and support of local programs.

Local Program Contractor Responsibilities

Funding for local program contractor will support established organizations to expand local advocacy efforts to increase access to culturally appropriate and responsive services and supports. The local program contractor will be responsible for the following:

- Providing local level advocacy to increase awareness of and access to mental health resources to the identified population.
- Providing training and education to counties, and mental health service providers on culturally and linguistically appropriate services for the identified population.
- Conducting and facilitating county roundtables to connect community partners serving immigrants and refugees.
- Collaborating with the State-Level Contractor.

State-Level Advocacy Contractor Responsibilities

The State-Level Advocacy Contractor will work with the four local programs to provide technical assistance and support to enhance the capacity of the grassroots organizations to advocate at the local level for more accessible and culturally relevant mental health services. The State-Level Advocacy Contractor will also be responsible to represent the needs of immigrants and refugees through state-level advocacy and policy engagement. The State-Level Advocacy Contractor will be responsible for the following:

- Providing state level, state wide advocacy.
- Supporting the four local contractors through technical assistance and capacity building for the local organizations to provide local level advocacy to increase access and culturally relevant mental health services and supports.
- Collaborating with the Local Program Contractors.

Minimum Qualifications

The following minimum qualifications must be met.

Local Program Contractors

All eligible bidders must:

1. Have been in existence for at least two years in providing direct outreach and engagement to the identified population;
2. Have experience and capacity to engage the identified immigrant and refugee population;
3. Be a non-profit organization, registered to do business in California; and
4. Have staff that have been employed by the organization for at least one year.

State-Level Advocacy Contractor

All eligible bidders must:

1. Be an established state-level organization with experience with programs and services related to the unique mental health needs of California's diverse immigrant and refugee populations;
2. Have experience and capacity to provide technical assistance and support to local community based organizations;
3. Be a non-profit organization, registered to do business in California;
4. Have experience and capacity to engage communities reflective of California's immigrant and refugee populations.

RFP Timeline

- February 15, 2019: RFP released to the public
- April 5, 2019: Deadline to submit proposals
- April 25, 2019: Commission issues Notice of Intent to Award