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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
March 28, 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

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

March 28, 2019
9:00 AM – 4:30 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
March 28, 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, Marisol Beas**.** Roll call will be taken.

9:10 AM **Announcements**

9:20 AM **Consumer/Family Voice**
Meghan Stanton will open the Commission meeting with a story of recovery and resilience.

9:40 AM **Action**
1: Approve February 28, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the February 28, 2019 meeting.

- Public Comment
- Vote

9:45 AM **Action**
2: Mono County Innovation Plan (Extension)
Presenters:

- Robin K. Roberts, MFT, Director of Mono County Behavioral Health
- Dr. Rick Goscha, Sr. Vice President, California Institute for Behavioral Health Solutions

The Commission will consider approval of Mono County's request for an additional four months, and an additional $84,935 to support the Easter Sierra Learning Collaborative: A County Driven Regional Partnership Innovation Plan previously approved by the Commission on Septemebr 28, 2017.

- Public Comment
- Vote

10:15 AM **Action**

3: San Mateo County Innovation Plan (Extension)

Presenters:

- Dave Pine, Supervisor, San Mateo County, District 1
- Lisa Putkey, MA, Program Director, San Mateo County Pride Center
- Andres Loyola, Peer Support Worker, San Mateo County Pride Center
- Ryan Fukumori, PhD, Research Associate, Resource Development Associates
- Scott Gilman, MSA, CBHE, Director, San Mateo County Health, Behavioral Health and Recovery Service

The Commission will consider approval of San Mateo County's request for an additional two years and an additional $1,550,000, to support the LGBTQ Behavioral Health Coordinated Services (The Pride Center) Innovation Plan previously approved by the Commission on July 28, 2016.

- Public Comment
- Vote

10:45 AM **Action**

4: Tulare County Innovation Plans

Presenters for the Metabolic Syndrome Pilot Project:

- Alisa L. Huff, PsyD, Lead Psychologist
- Lester E. Love, M.D., Medical Director
- Sander Valyocsik, M.A., Consultant, Societas, Inc.

Presenters for the Connectedness 2 Community Project:

- Carol Davies, Consultant, Davies and Associates, Inc.
- Michele Cruz, Mental Health Services Act Manager

The Commission will consider approval of $1,610,734 to support the Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication, and $1,320,684 to support the Connectedness2Community Innovation Plans.

- Public Comment
- Vote

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**

(Closed Session – Government Code Section 11126(a) related to personnel)

2:00 PM **Report Back from Closed Session**

Chair Khatera Tamplen will report back on any reportable action taken during closed session.

2:15 PM **Action**

5: Legislative and Budgetary Priorities

Presenters:

- Sarah Couch, Legislative Director, Office of Senator Bates
- Toby Ewing, Executive Director, MHSOAC

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 positon on the following bills:
Senate Bill 582 (Beall) and Senate Bill 604 (Bates).

- Public Comment
- Vote

3:15 PM **Information**

6: 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

4:15 PM **General Public Comment**

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

4:30 PM **Adjourn**

Back to Agenda

AGENDA ITEM 1

Action

March 28, 2019 Commission Meeting

Approve February 28, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the February 28, 2019 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) February 28, 2019 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the February 28, 2019 meeting minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
February 28, 2019

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

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Mayra Alvarez
Senator Jim Beall
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Reneeta Anthony
Assemblymember Wendy Carrillo
Itai Danovitch, M.D.
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Tom Orrock, Chief of Commission Operations and Grants
Sharmil Shah, Psy.D., Chief of Program Operations

CONVENE AND WELCOME

[Note: Agenda Item 4 was taken out of order. These minutes reflect this Agenda Item as listed on the agenda and not as taken in chronological order.]

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:08 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and announced a quorum was not yet present. A quorum was achieved after Commissioner Mitchell arrived.

Chair Tamplen reviewed the meeting protocols.

Youth Participation

Chair Tamplen stated 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. Gabriel Garcia introduced himself.

Announcements

Sharmil Shah, PsyD, MHSOAC staff, introduced new staff member Vicque Kimmell, Ph.D., who joined the Commission as part of the Plan Review team.

Chair Tamplen announced the names of the chairs and vice chairs of Committees and Subcommittees for 2019.

- **Client and Family Leadership Committee (CFLC)**

Mayra Alvarez, Chair; Reneeta Anthony, Vice Chair

- **Cultural and Linguistic Competence Committee (CLCC)**

Gladys Mitchell, Chair; Keyondria Bunch, Ph.D., Vice Chair

- **Evaluation Committee (EC)**

Itai Danovitch, M.D., Chair; Ken Berrick, Vice Chair

- **Innovation Subcommittee**

John Boyd, Psy.D., Chair; Itai Danovitch, M.D., Vice Chair

Members of the Innovation Subcommittee will include Commission Vice Chair Lynn Ashbeck, Tina Wooton, Dave Gordon, and Reneeta Anthony.

- **Prevention and Early Intervention Subcommittee**

Mara Madrigal-Weiss, Chair; Mayra Alvarez, Vice Chair

- **Schools and Mental Health Subcommittee**

Dave Gordon, Chair; Gladys Mitchell, Vice Chair

Members of the Schools and Mental Health Subcommittee will include Ken Berrick.

- **Suicide Prevention Subcommittee**

Tina Wooton, Chair; Commission Chair Khatera Tamplen, Vice Chair

Members of the Suicide Prevention Subcommittee will include Mara Madrigal-Weiss.

- **Assembly Bill (AB) 1315 Early Psychosis Intervention Plus (EPI Plus) Subcommittee**

Commission Chair Khatera Tamplen, Chair

Members of the AB 1315 EPI Plus Subcommittee will include Itai Danovitch, M.D., Gladys Mitchell, and Mara Madrigal-Weiss.

Chair Tamplen thanked Commissioners for their leadership and stated she would be happy to add other Commissioners to the Committees and Subcommittees who are interested in joining.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Corinita Reyes to share her story of recovery and resilience.

Corinita Reyes shared her story of living with bipolar schizoaffective disorder and how she came to the point of participating in BESTNOW!, a peer specialist training program, and her internship with the Office of Consumer Empowerment in Alameda County. She stated having doctors and professionals telling her what is best for her and what she can and cannot do while slapping labels on her has not helped her in any way. Instead, they hurt her and made her feel broken rather then what she really is: a resilient, talented, open-minded person with unique perspectives and experiences. She stated she is participating in the Pool of Consumer Champions (POCC) and a Wellness Recovery Action Plan (WRAP) group of peers to maintain and manage her wellness. She stated what has helped her the most has not been clinicians, doctors, or therapists with years of experience from a book but rather community-run organizations, music, peer supporters, and talking openly about her experiences with others.

Commissioner Questions and Discussion

Commissioner Boyd stated one of the things that stood out for him during Ms. Reyes's presentation was the impact of housing and transportation as significant barriers. He stated Proposition 63 dollars have funded advantageous programs such as music and other programs mentioned in the presentation in densely-populated but most expensive parts of the state. He asked where those helpful programs and services are outside of densely-populated cities and if there is technology that can be leveraged in rural settings where housing is more affordable.

ACTION

1: <u>Approve January 24, 2019, MHSOAC Meeting Minutes</u>

Chair Tamplen asked to include "are cases that" to her comment on page 6 so it would read "which implies that people are cases that need to be managed."

Public Comment

Rory O'Brien, LGBTQ Program Coordinator, Mental Health America of Northern California (NorCal MHA), Project Coordinator, #Out4MentalHealth, asked to remove the first sentence from their comment at the bottom of page 29.

Smitha Gundavajhala, Youth Leadership Institute, questioned the practice of condensing some public comments to the single line that they spoke in support or in opposition to issues. Some public comments carry separate and unique points. The speaker asked the Commission to record and provide a full transcript of the meetings.

Commissioner Gordon suggested making the recording of meetings available online for anyone who wishes to make a transcript for themselves.

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

The Commission approves the January 24, 2019, Meeting Minutes.

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Beall, Berrick, Boyd, Brown, Bunch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Tamplen.

The following Commissioner abstained: Vice Chair Ashbeck.

ACTION

2: Immigrant and Refugee Request for Proposal (RFP) Revision

Presenter:

- Norma Pate, Deputy Director, MHSOAC

Chair Tamplen stated the Commission will consider a revision to the Immigrant and Refugee RFP outline. She stated Norma Pate, Deputy Director, was unable to be in attendance and that Tom Orrock would present this agenda item in her place.

Tom Orrock, Chief of Commission Operations and Grants, provided an overview, with a slide presentation, of the background, concerns, distribution of funding, and options to fund a fifth immigrant and refugee stakeholder contract.

Toby Ewing, Ph.D., Executive Director, stated staff's ability to support local contractors in capturing the statewide messaging and bringing that into the Commission's and Legislature's work was also discussed. He stated part of Option 2 was to provide the opportunity to award contracts to local organizations and then to work with them to support messaging at the statewide level. The fifth contract would play that role. He stated, for Option 1, staff would have some capacity for statewide messaging but not to the extent that a contractor would have.

Commissioner Questions

Commissioner Boyd asked if this is an opportunity to go to organizations such as the Sierra Health Foundation or the California Endowment that are already doing work with these populations for matched funding or collaboration.

Executive Director Ewing stated it is. He stated part of the issue is if the Commission would be raising funds on behalf of other organizations. He stated the Commission will attempt to position the recipients of these funds to do that work themselves as a sustainable strategy through the technical assistance role of the Commission.

Commissioner Boyd suggested tying this work into what is known about major bodies of work around health equity, which is the natural tie-in for broader support. He volunteered to be at that table with a few other organizations to help with that.

Commissioner Brown asked about the increase in the level of the distribution of funding from year one to years two and three. He asked, if the funds were evened out, if the funds could be used to restructure a state-level contract to have funding in year one.

Executive Director Ewing stated the reason for the delayed timing of the statewide contract is to allow time to put the local contracts in place so the statewide contract could be designed around their needs. He stated small nonprofit organizations shared with staff that it would be difficult for them to begin spending the funding in year one due to the necessary ramping-up process. He stated there typically are opportunities to make adjustments in the timing while working with the small nonprofits around cashflow issues.

Vice Chair Ashbeck asked if the Commission is solving for the wrong problem since $122,000 does not seem like enough money.

Executive Director Ewing agreed that $670,000 is insufficient but stated this small amount of available funding will be lost if not encumbered prior to June 30th, the end of the fiscal year. The Commission is looking into ways of supplementing the funding. He stated he anticipates applications from organizations with a core focus in a specific area. The idea is to start to

provide support to nonprofit organizations who work specifically with immigrants and refugees on behavioral health challenges.

Commissioner Gordon stated it is not effective for the Commission to support the development of small nonprofit organizations. He suggested, in the future, awarding a grant to an intermediary agency on the Commission's behalf to put out procurements to select agencies and to small nonprofits.

Gabriel Garcia stated his organization works with refugee communities around the state, specifically Southwest Asian communities. They do great work when it comes to direct service and engaging communities that have not had resources that are culturally competent. The concern is the great work being done is not often seen by their counties that should be supporting and funding them. He stated the more immigrant and refugee communities that receive advocacy funding, the more it can bring attention to other communities in other areas.

Public Comment

Poshi Walker, LGBTQ Program Director, NorCal MHA, Co-Director, #Out4MentalHealth, stated deep concern about how this RFP is constructed. The speaker stated the California Reducing Disparities Project (CRDP) had five diverse populations that came together to form a strategic plan because these populations still had many things in common in terms of disparities. The lack of one strong voice in this project is concerning. The speaker agreed with Commissioner Gordon about awarding a grant to an intermediary agency on the Commission's behalf. #Out4MentalHealth has given out subcontracts to five local regions for task forces. The speaker stated, while the money given to them is helpful, what is even more helpful is the fact that #Out4MentalHealth has the capacity to support them. The MHSOAC staff does not have the time it takes to run task forces. The speaker suggested requesting to extend the funding time. There is a problem with time constraint versus doing it right and doing it effectively.

Poshi Walker advocated for a statewide contractor to be the Commission's intermediary and for including in the RFP the fact that the statewide contractor must engage a certain number of populations. The speaker suggested letting the statewide contractor write the state of the communities' report to the Commission. These service providers are amazing because they work in their community as service providers, which is different from being an advocate and doing outreach and training. Service providers do not know how to suddenly taken on an advocate role.

Ricardo Sainz-Ayon, Policy Associate, California Pan-Ethnic Health Network (CPEHN), stated CPEHN interviewed over twenty counties, community-based organizations, and immigrant advocates last year for their report, Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. One challenge is that many local organizations working with immigrant and refugee communities have limited knowledge of the public mental health system. A major recommendation that emerged was to be able to provide technical assistance to these organizations. The speaker stated CPEHN would be concerned about the success of this work if the statewide contract is eliminated, unless the MHSOAC has a proposal to bolster its internal capacity and expertise in this area. The speaker stated CPEHN believes that there is a need to convene local organizations around statewide advocacy in order to make the systemic changes that are necessary to properly serve these populations. The speaker stated CPEHN recommends against Option 1 and the elimination of the statewide contract.

Rory O'Brien strongly recommended against eliminating the statewide contract. The issues faced by immigrant and refugee communities are individual and systemic, thus requiring local and statewide response. The speaker also recommended against further fragmentation of funds into smaller projects. The speaker recommended looking to models that the Commission is

already funding, such as #Out4MentalHealth, which is funding local work in all regions across the state, and the CRDP Phase 2, which has technical assistance providers that support local community-based organizations that are doing this work. The speaker spoke in opposition to Option 1. The speaker recommended keeping the RFP as released, which is a statewide option with four contracts at the local level.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated the community learned of this significant RFP change less than one week ago. None of the letters received are in favor of Option 1, which removes the state-level piece. There is a misunderstanding of the communities. Communities do not want a one-size-fits-all option, which is different from not wanting advocacy at the state level. Advocacy at the state level is very needed. The speaker spoke in opposition to Option 1. The option should be as Rory O'Brien stated: to keep the RFP as released.

Smitha Gundavajhala suggested using a hub-and-spoke model with a central hub that helps coordinate the different spokes, which are specialized in their reach. The idea is to empower the spokes to do the best reach in their communities rather than burden them with additional administrative work. The speaker stated concern that the Commission is mistaking a reach-with-support option. While it is important to reach communities, if they are not adequately supported, these contracts may be unsuccessful and, ultimately, immigrants and refugees will not see gains. It is helpful to have a statewide board or a way to coordinate representatives from organizations across the state but not necessarily to suggest that there is no opportunity for collaboration and statewide advocacy. Having a statewide mechanism to centrally support local groups is important as long as they are empowered.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, echoed Commissioner Gordon's concerns about the funding and seconded Poshi Walker's comments. The speaker encouraged the Commission to look at the existing stakeholder contractor models. ACCESS California, like #Out4MentalHealth, is doing work in all five regions of California. It is important to have a strong statewide advocacy component that can provide monetary and technical assistance support at the local levels throughout California. The speaker spoke in opposition to Option 1. The speaker recommended an Option 3 – to model the RFP after the existing stakeholder contracts.

Lee Lo, Policy Associate, Southeast Asian Resource Action Center (SEARAC), echoed the comments of previous speakers. The speaker urged against the elimination of the state contractor because many community-based organizations that provide mental health services do not have advocacy capacity or experience in that area. Removing the state contractor essentially makes the RFP accessible to organizations that already have experience with advocacy and already have that capacity. Separating the contracts across five regions will fund one full-time advocate plus some community projects to do education to build advocacy. One full-time advocacy staff is not enough to make systematic change even at the local level. The speaker stated it is imperative that this RFP is successful in improving immigrant and refugee mental health to support future opportunities to expand advocacy capacity to these communities. If it is not done effectively and efficiently, there will be less opportunities in the future for funding for these communities. Regardless of how the outline has already been released, the SEARAC would much prefer it to the options presented today. The speaker suggested not just looking at population size but the severity of need.

Commissioner Discussion

Commissioner Madrigal-Weiss stated that she heard loud and clear from the community-based organizations at one of the community forums held on this issue that community-based organizations best serve, look like, and speak like their communities and know the interventions.

Oftentimes what happens is that the county dollars go to the county, the county develops a plan to meet with a certain number of families, and then contracts a small percentage of the funding with local community-based organizations that are doing massive amounts of work and making the change. She stated the need for this not to be either/or but and, and also not to have someone such as the county speaking for the community-based organizations, but allowing the community-based organizations to speak for themselves and to design what works for them and their communities.

Gabriel Garcia stated one of the advantages of a statewide contractor is the local community-based organizations are engrained in their communities but there are many opportunities where only a statewide advocate can be in the room. Having a statewide entity that is intentionally working with them and learning about the local issues and needs that communities are facing can then represent that in spaces that are not always accessible to those at the local level. Systemic change will always come from the state Legislature. There needs to be momentum at the statewide level to ensure that local voices are represented.

Commissioner Brown suggested an Option 3 – to change the formula for the funding for the local grants, keep it at $90,000 for the first year, change it to $100,000 for the second year, and $110,000 for the third year. He suggested taking the funds that could be swept out and putting them toward the state contract level so there would be approximately $520,000 over the three years. It would keep the five contracts and would also keep the state contract for three years.

Executive Director Ewing stated changing the terms of the available funding may require reissuing the RFP. He suggested resolving the issue today while pursuing additional long-term options through the legislative budget process and immediately through partners in philanthropy.

Commissioner Boyd stated approving one of the two options would allow the Commission to quickly move to partners including the corporate sector to fill in that funding gap. There would be strong interest in that. He asked if Option 1 or 2 would be easier for staff to manage.

Executive Director Ewing stated staff can manage both but Option 2 is to make no change.

Commissioner Boyd made a motion to adopt Option 2 as written on the presentation slide.

Commissioner Gordon stated the original proposal was not to have a state-level contract in the first year. He agreed with the members of the public that having a state contract is important. He suggested stressing the need for a statewide contractor to the Legislature and a contractor who could assist the local grantees to build their capacity as an intermediary.

Executive Director Ewing clarified that, if the Commission chooses to modify the RFP to allow five local contracts and is successful in raising funds, it may not delay the state-level contract.

Commissioner Mitchell suggested that the decision-making and resources for communities be kept at the local level while looking for opportunities in the future to get support from private entities for statewide support.

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

The Commission revises the January 2019 outline for the Immigrant and Refugees stakeholder contracts to: increase the number of local program contracts from four to five, one for each of the California regions; eliminate the statewide program contract; and distribute the total funding equally to each of the five local program contracts.

The Commission directs the Executive Director to make the necessary changes to the RFP that was released on February 15, 2019.

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Beall, Berrick, Boyd, Brown, Bunch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Tamplen.

The following Commissioner abstained: Vice Chair Ashbeck.

Chair Tamplen stated the Commission will continue their efforts to ensure that the statewide piece is represented.

Vice Chair Ashbeck stated the need for the Commission to figure out how to address the question of the size of the regions. The need in small counties is in some ways more intense than in larger counties due to the lack of services.

INFORMATION

3: Strategic Planning Update

Presenters:

- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig, Vice President of Evaluation, Applied Survey Research

Chair Tamplen stated the Commission will hear an update from Applied Survey Research on the progress and status of the Commission's strategic planning process and engage in a facilitated discussion. She thanked Vice Chair Ashbeck for taking the lead and facilitating the strategic planning process.

Vice Chair Ashbeck stated this process began under the leadership of former Chair Boyd. She stated it began with several objectives: a shared understanding of the work of the Commission, the scope of the Commission's work, a clarity of roles, engage stakeholders, and set priorities.

Susan Brutschy, President, Applied Survey Research (ASR), stated the purpose of ASR's work is a results-based strategic planning process. She recognized the Commission staff who are a part of the Design and Staff Teams. She provided an overview, with a slide presentation, of the themes gathered through the interviews and survey responses, four core functions of the Commission, and where the Commission is in the strategic planning process.

Lisa Colvig, Vice President of Evaluation, Applied Survey Research, continued the slide presentation and discussed the updated Theory of Change/Organizational Roadmap.

Executive Director Ewing handed out the Use of Commission Time in 2018 represented with pie chart graphics in five categories: innovation, administrative, strategic planning process, policy projects, and legislative and policy. He stated he discussed at the last Commission meeting the expansive nature of the Commission's authority contrasted with the constraints of time, staff, and funds. He stated the pie chart graphics will help Commissioners determine if Commission meetings make the best use of Commissioner time. He stated a discussion will be scheduled for the March or April Commission meeting about how to make more strategic use of the Commission's time, talents, staff, and resources.

Commissioner Questions and Discussion

Commissioner Brown suggested delegating more of the innovation plan approval process to staff so the Commission would approve more on an administrative basis rather than directly hearing from every county on every plan.

Chair Tamplen agreed and suggested the Innovation Subcommittee could help streamline the process.

Commissioner Gordon referred to the Organizational Roadmap slide and suggested including the word “where” in the blue bubble so it would read “everybody who needs care gets care when and where they need it.” He stated the where is becoming a larger item in his county.

Commissioner Boyd asked if there is any prevention and early intervention (PEI) in that blue bubble. He stated the current language is care-based.

Executive Director Ewing stated the draft language will continue to be improved.

Public Comment

Poshi Walker stated the need for Commissioners to have the time to do their job in a way that is truly meaningful and effective. The speaker suggested looking at the structure of Commission meetings to figure out if there is a way to have fewer agenda items to allow more time for each item and to schedule meetings so Commissioners do not have to leave early to catch flights, even if that means two-day meetings.

Rory O’Brien echoed Poshi Walker’s comments. The speaker criticized not the Commission but the structure within which it works. Commissioners expressed a lack of information and understanding of their role on the Commission, the extent and form of power that they hold over the lives of Californians, and the scope of the Commission’s work during the strategic planning meeting and on a regular basis in monthly meetings, including today with the motion on the immigrant and refugee RFP. Commissioners work from a place of confusion and have made motions and voted without clarity to the language of the motion that they are voting on and without a level of advanced education and briefing on the topic that they are voting on. Commissioner training, development, and information support is lacking in the current strategic plan. Commissioners are not at fault for this but are being made to walk through a dark room. The speaker suggested that Commissioners demand training from staff, greater preparation for their votes, and written clarity of what they are making decisions on.

David Nufer, Depression and Bipolar Support Alliance, stated it would be helpful for organizations to learn how to effectively engage with the Commission. He noted how big a task Commission staff has compared to the relatively small manpower and that staff often looks tired at the start of meetings.

Steve Leoni, consumer and advocate, echoed Rory O’Brien’s comments in the same spirit that is it not a criticism of the individuals sitting around the table but it is a structural issue that needs to change. He stated it would have been nice for Commissioners to have the strategic planning document, which was just handed out, a week ago so they could digest it, consider it, and come to the meeting with intelligent, strategic questions.

Steve Leoni stated a presentation slide states, if these things are done in these ways, there will be success. The speaker stressed the phrase “in these ways” and stated there is an engrained stigma in the clinical community.

Steve Leoni suggested a review of the Mental Health Services Act (MHSA) component that talks about adult services and the community services and supports (CSS) component regulations.

[Note: Agenda Item 4 was taken out of order and was heard after Agenda Item 7.]

ACTION

4: Legislative and Budgetary Priorities for 2019

Presenter:

- Toby Ewing, Ph.D., Executive Director

Chair Tamplen stated the Commission will be provided with an update on legislation that the Commission has taken a position on in 2019 and will consider additional legislative and budgetary priorities. She invited Executive Director Ewing to present this agenda item.

Executive Director Ewing stated the materials provided in the meeting packet identify two issues:

1. The governor's budget included funding to create an early psychosis program and proposed to put $25 million to support that program into the budget of the Department of Health Care Services (DHCS).

   Last year, the governor and the Legislature established an early psychosis program that the Commission runs, which had no funding.

   Executive Director Ewing stated it does not make sense to have two programs that are operating independently. He stated the request is to authorize staff to work with the governor and the Legislature to propose the merging of the two proposals, starting with bringing the funding in to support the existing program or moving the existing program to the DHCS, where the funding is.

2. In the conversation with the counties and stakeholders around the design of the innovation incubator, three needs were identified:

   - Clarify the Commission's rules for support innovation proposals as a way to streamline the process.
   - Support an innovation incubator. A one-time funding amount of $5 million was received from the Legislature focused on criminal justice. Staff was directed to try to transition that to be ongoing funding.
   - Better understand what everyone else is doing and access technical assistance to strengthen what everyone else is doing with innovation, PEI, full-service partners, CSS, and other programs with information-sharing.

   Executive Director Ewing stated the request is to direct staff to engage the governor and the Legislature to secure funds to build a strategy to respond to that need for technical assistance to better keep track of what is happening around the state so collective learning can happen.

Public Comment

Stacie Hiramoto stated early psychosis identification serves the least number of individuals compared to other types of PEI approaches. It is incumbent upon the Commission to educate the Legislature that racial and ethnic and particularly immigrant and refugee communities would not prioritize early psychosis identification programs.

Anna Hasselblad, United Ways of California, spoke about policy and budgetary priorities of United Ways of California that would be shared by this Commission, particularly around PEI in school-based community-based services and care, integrated health services, and AB 875 and the Healthy Start Initiative.

Adrienne Shilton spoke in support of the motion to merge the $25 million with the early psychosis program. The speaker stated the Steinberg Institute is also working with the administration on the alignment of the two.

Steve Leoni spoke in support of the motion to merge the $25 million with the early psychosis program but suggested that the Commission run it, not the DHCS. The DHCS's idea of a stakeholder process is a webinar with occasional questions answered.

Steve Leoni stated the technical assistance piece with the innovation incubator also needs to be technical assistance around financial issues.

Janis Connallan, Children's Defense Fund, spoke in support of putting the $25 million into the Commission's early psychosis program. The speaker stated concern about it going into the DHCS. The speaker echoed the comments of Anna Hasselblad and stated the Children's Defense Fund is partnering with United Ways of California to modernize and restore the Healthy Start Program.

Hellan Roth Dowden, Teachers for Healthy Kids, spoke in support of the proposal to keep the funding with the Commission rather than sending it to the DHCS. It is important to begin the early psychosis program as quickly as possible.

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

The MHSOAC directs staff to work with the administration and the Legislature to merge the $25 million General Fund with the Commission's AB 1315 early psychosis program.

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

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

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

The MHSOAC directs staff to work with the administration and the Legislature to try to secure funding for technical assistance for the counties and the different aspects of mental health services to better keep track of what is happening around the state so collective learning can happen.

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

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

ACTION

5: <u>Nevada County Innovation Plan</u>

Presenters:

- Phebe Bell, MSW – Director of Behavioral Health, Nevada County
- Priya Kannall – MHSA Coordinator, Nevada County
- Gayatri Havighurst, RN – Peer Specialist, SPIRIT Peer Empowerment Center

Chair Tamplen stated the Commission will consider approval of $2,395,892.02 to support the Nevada County Homeless Outreach and Medical Engagement (HOME) Team Innovation Plan. She asked the representatives from Nevada County to present this agenda item.

Phebe Bell, MSW, Director of Behavioral Health, Nevada County, provided an overview, with a slide presentation, of the need, proposed solution, and budget of the proposed innovation project.

Priya Kannall, MHSA Coordinator, Nevada County, continued the slide presentation and discussed the innovative components and evaluation of the proposed innovation project.

Gayatri Havighurst, RN, Peer Specialist, SPIRIT Peer Empowerment Center, continued the slide presentation and discussed the sustainability of the proposed innovation project.

Sheriff Shannan Moon spoke in support of the proposed project.

Commissioner Questions

Chair Tamplen asked that the peer specialist salary be improved and that they be able to become the team lead.

Gabriel Garcia asked about the point of contact with this program.

Ms. Bell stated the county currently has staff who regularly visit the jail. They will be assisting with the warm handoff to this team. The jail also informs the county about individuals whom they think could benefit from services so the county can start building a relationship prior to release. A challenge is individuals who are booked and released quickly. Law enforcement in the field is helpful in this area so the county can engage individuals prior to booking or can work proactively to inform the county of individuals they are concerned about.

Commissioner Beall stated the proposed innovation plan fits in with what the governor has been discussing. The current budget has a total of $7.7 billion for housing. He suggested researching permanent funding for housing. He stated Proposition 1 has a set-aside specifically for rural counties of $300 million. A Notice of Funding Availability (NOFA) will soon be coming out from the Housing and Community Development Department. He stated the warm handoff with law enforcement is essential. More laws will be coming up that will help facilitate this type of relationship with housing, criminal justice, and homelessness. He stated he would send the list of housing funding type bills to Commissioners. He suggested that staff identify opportunities for housing funding in future innovation plan proposals.

Vice Chair Ashbeck asked about the length of time individuals will be allowed to stay in the shelter.

Ms. Kannall stated it will not quite be a lease but there would be an admission agreement for an initial one-year period with the opportunity for extension. The idea is to pair it with more permanent housing units.

Public Comment

Robb Layne, Director of Communications and External Affairs, County Behavioral Health Director's Association (CBHDA), spoke in support of the proposed project.

Michelle Hendricks, Vice President, National Alliance on Mental Illness (NAMI), read the letter NAMI submitted to staff in support of the proposed project.

Ashley Brand, Sierra Nevada Memorial Hospital, spoke in support of the proposed project.

Amanda Wilcox, Nevada County Mental Health and Substance Use Advisory Board, spoke in support of the proposed project.

Adrienne Shilton, Steinberg Institute, spoke in support of the proposed project.

Commissioner Discussion

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

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

Name: Homeless Outreach and Medical Engagement (HOME) Team

Amount: $2,395,892.02

Project Length: Five (5) Years

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

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

GENERAL PUBLIC COMMENT

Virginia Hall, Alameda County Behavioral Health (ACBH) Pool of Consumer Champions (POCC), asked that a broader look be given to supporting resources and services for older adults and seniors who are struggling with mental health issues.

Poshi Walker agreed with Smitha Gundavajhala's comment this morning about condensing public comment in the minutes. Including public comment in print becomes an advocacy point and shows that the public has been heard. The speaker encouraged Commissioners to acknowledge that they have heard the public during the public comment period, even if not in agreement. It is helpful to know that public comments are part of the decision-making process.

Poshi Walker asked that the expertise and experience of current advocacy contractors be used in the development of future RFPs. There is no need to reinvent the wheel when effective models have already been developed. The speaker stated a statewide presence is essential. The speaker encouraged one or more Commissioners to make a motion to direct MHSOAC staff to ask for additional legislative funding for the next budget round to support a statewide contractor for the refugee and immigrant project.

Stacie Hiramoto echoed Poshi Walker's comments. Corinita Reyes's comments this morning were powerful. The speaker shared their cousin's experience of living with a serious mental illness. The speaker stated they do this work for their family and community and, although they and the Commission do not always agree, they appreciate the work of the Commission and believe everyone wants the same thing: appropriate services for individuals when they need it.

LUNCH BREAK

ACTION

6: <u>Imperial County Innovation Plans</u>

Presenters for the Link Crew Collaborative:

- John Grass, Deputy Director of Youth and Young Adult Services
- Sylvia Bazan, Behavioral Health Manager of Youth and Young Adult Services

Presenters for the Positive Engagement Team (PET):

- Leticia Plancarte-Garcia, Deputy Director of Children Services
- Maria Lara Wyatt, Behavioral Health Manager of Children Services

Chair Tamplen stated the Commission will consider approval of $1,911,084 to support the Link Crew Collaborative Innovation Plan, and $3,120,109 to support the Positive Engagement Team (PET) Innovation Plan. She asked the representatives from Imperial County to present this agenda item.

Andrea Kuhlen, Director, Imperial County Behavioral Health Services, summarized the community planning processes for the proposed innovation plans.

Link Crew Collaborative

John Grass, Deputy Director of Youth and Young Adult Services, provided an overview, with a slide presentation, of the need and evaluation of the proposed innovation project.

Sylvia Bazan, Behavioral Health Manager of Youth and Young Adult Services, continued the slide presentation and discussed the proposed solution and innovative components of the proposed innovation project.

Commissioner Questions

Commissioner Gordon asked who in the school was consulted in putting this proposal together.

Mr. Grass stated the county met with superintendents, principals, school psychologists, school counselors, and teachers in each of the districts for Brawley Union High School, Central Union High School, and Southwest High School.

Commissioner Gordon questioned that high school juniors and seniors should be entrusted to make referrals for conditions. He stated this seems risky.

Mr. Grass stated the mental health rehabilitation technician or case manager would be at the site to discuss concerns of the students. The junior and senior students would not be put in a position to assess or diagnose. They will bring concerns to the technician.

Commissioner Gordon stated the problem is, as soon as a person is identified to the technician, everyone will know that that identification was made. He advised caution due to the culture of the school environment, especially in the case where students are coming for the first time to a large high school environment.

Mr. Grass stated the Link Crew training will include a component for confidentiality and students who serve as Link Crew advisors will sign an agreement to abide by the terms and conditions of confidentiality. Communications that would take place would not be in a group setting but would be between the student mentor and the rehabilitation technician.

Commissioner Madrigal-Weiss stated her concern that the proposed project will be brought into the school versus having the school adopt it and make it their own. She stated outside staff will be working with the county. The culture and behavior of the adults can only start to change when the school does programs for themselves that include their staff. She stated the presenters used numbers to talk about school climate, yet focuses on youth and identifying if they have an issue based on what another young person would determine could be a concern. Although students will not diagnose, it is a huge responsibility which, if missed, would be a concern.

Commissioner Madrigal-Weiss asked how a child could be held legally responsible for keeping confidentiality. This is also a concern. The presenters used data to describe school

connectiveness, but then also spoke to mental health issues. Even in the California Healthy Kids Survey, there is specific data around seriously contemplating suicide or something that would speak to mental health. Using data to try to explain behaviors around mental health is like comparing apples to oranges.

Ms. Bazan stated the county will be working in collaboration with the schools and will be teaching the Link Crew mentors, who are the students, basic engagement skills, which does not go into anything clinical or therapeutic. The county will also be educating the teachers and the advisors on mental health issues with an anti-stigma approach and outreach and also to help them understand about services offered by this program. She described the program process from the application, screening, interview, and selection processes to putting the selected youth through orientation and the curriculum, assigning the youth their five- to six-person caseloads where they will engage in group activities and one-on-ones, identifying issues, and referring fellow students to school staff at the family resource center who will refer students to the mental health rehabilitation technician case manager who will do the prescreening.

Commissioner Mitchell agreed with Commissioner Gordon's concern about putting the responsibility on the students. She stated, in her efforts to run mentoring programs on school campuses, she uses children who have leadership abilities to help other students. What she found is that, even with the best students, children's attention spans are short. She stated her concern about assigning a student something of this magnitude. Resources would be better served in additional counselors dealing with mental health issues or early identification or something to help current staff, teachers, or counselors on campuses to identify and provide services for students, as opposed to having students as peer mental health workers in this capacity. She asked who is doing the program on the campus to help train the Link Crew.

Ms. Bazan stated it is one of the county's behavioral health community service workers.

Chair Tamplen agreed with Commissioner concerns about the Link Crew mentors and added the additional concern about the break of trust among the young people. She asked if the Link Crew curriculum was developed by young people who have experience with mental health issues and if consumers and young people were involved in modifying the curriculum. She stated her concerns about privacy issues, keeping individual stories from being exploited on social media, and the fact that young people may want to be in conversation with the mentor for a period of time versus immediately being referred. She suggested using the term "support specialist" as opposed to "case management" or "caseloads," which implies that people are cases that need to be managed. Instead the specialists are supporting individuals in their journey.

Gabriel Garcia agreed with Commissioner Mitchell about the amount of responsibility being put on the young people where they are seen as guardians to direct peers towards mental health resources. He stated one of his biggest concerns is how that will be structured. He suggested the revision that the youth mentors know that they have an option to refer to a mental health resource but do not have that responsibility. That distinction may help to make a difference. Charging youth with the responsibility of the mental health of their peers is a stretch. He asked if youth were consulted with the development of this proposal.

Mr. Grass stated there was some youth participation in the early community planning process. The application of the Link Crew was done only with school personnel.

Gabriel Garcia asked about the top-level outcomes and feedback given by the youth who participated in the focus groups and hearings.

Mr. Grass stated one of the primary identifiable issues was access to mental health, as well as recognizing that there are behavioral and emotional problems within the population, not having

access to services, stigma, and the school and parents being unprepared to address mental health issues.

Gabriel Garcia asked if the youth provided feedback on what their role would be in this proposal.

Mr. Grass stated they did not.

Commissioner Alvarez asked if other opportunities were explored to use the Link Crew space other than identifying cases, such as creating resiliency, tools, and resources in the community that then would be spread throughout the school. She reminded Commissioners that the Commission approved San Francisco County's innovation plan at the last meeting, which was similar to this plan. She asked if there is an opportunity to integrate San Francisco County's approach as opposed to this case selection. She stated successful models show success through small groups by building relationships between six to eight people and building trust. The proposed project has the goal of approximately 500 students at three schools. This will be a challenge to build the trust it takes to make a safe space to support the wellbeing of students.

Mr. Grass stated the Link Crew curriculum lends itself towards doing exactly that. It has potential to be used as a launchpad for mental health training opportunities.

Commissioner Mitchell suggested that the county reframe and repackage the implementation vehicle.

Commissioner Brown agreed and encouraged the county to withdraw their proposal, retool it, and come back with a way that might address the issues of concern.

Ms. Kuhlen withdrew the county's proposal based on Commissioner comments and concerns.

Chair Tamplen thanked the project proponents for their presentation and stated the Commission looks forward to a revised proposal at a future meeting.

Positive Engagement Team (PET):

Maria Lara Wyatt, Behavioral Health Manager of Children Services, provided an overview, with a slide presentation, of the need, proposed solution, evaluation, budget, and sustainability of the proposed innovation project.

Leticia Plancarte-Garcia, Deputy Director of Children Services, continued the slide presentation and discussed innovative components of the proposed innovation project.

Commissioner Questions

Vice Chair Ashbeck asked about the number of individuals this project would reach.

Ms. Wyatt stated 2,500 individuals per year would be reached.

Vice Chair Ashbeck suggested piloting the project for one year to see the impact that animals might have rather than the five years requested. She questioned how a dog could reduce stigma.

Commissioner Gordon stated both he and Commissioner Brown, who had to leave, questioned the personnel cost of almost $2 million and costs for the dogs at approximately $700,000. The costs seem high just to make the environment more friendly.

Ms. Plancarte-Garcia stated the idea is to use clinicians and community service workers to do the outreach activities. The reason it is a five-year project is that it takes time to get started. Also, the county would like to integrate the program into different populations to compare the results.

Ms. Wyatt added that all of the staff will be newly hired for this project. She stated the contract with the Humane Society is $635,000. They will hire handlers and trainers. The cost will increase every year due to additional animals that will be necessary as the number of clients increases.

Commissioner Madrigal-Weiss stated the population of Imperial County is 84 percent Latino. She asked if the county researched other forms of reducing stigma in the Latino community. She agreed with Vice Chair Ashbeck's question of how the use of animals reduces stigma.

Ms. Plancarte-Garcia stated the Latino community was part of the community planning process and had recommended the use of animals for the reduction of depression and the effects of trauma.

Gabriel Garcia stated programs that include dogs are popular on college campuses. He stated his biggest concern is how the animal component turns into individuals receiving services.

Ms. Plancarte-Garcia stated the proposed project will help bring that understanding by tracking referrals.

Commissioner Bunch suggested shortening the program from five years to two years. Perhaps the proposed project is innovative and will decrease stigma and increase access, but five years seems like a long time to wait to know if this is effective.

Ms. Wyatt stated each year will focus on a different age population while serving the community as a whole. It takes time to train animals and find handlers.

Public Comment

Robb Layne spoke in support of the proposed PET project.

Smitha Gundavajhala stated concern that the proposed Link Crew Collaborative is not being informed on specific youth needs. The speaker agreed with Commissioner Gordon's comments about having a supportive cultural environment first and foremost. The speaker also stated concern that success is being defined by looking at disciplinary measures rather than health outcomes.

Poshi Walker stated innovation does not mean that the proposed PET project will succeed. The Commission has already approved several million dollars for an app that may not work. Regarding the outcome measures for the proposed Link Crew Collaborative project for decrease in absenteeism and truancy, the research shows that LGBTQ youth are overrepresented in those two populations. They do not go to school because they do not feel safe.

Poshi Walker referred to the outcome measure of a decrease in school disciplinary actions and stated LGBTQ youth are disciplined more frequently and more severely than their straight and cisgender counterparts and, along with students of color, are a part of the school-to-prison pipeline. This is an environmental issue, not an individual issue. Staff for this program should be trained on the needs of LGBTQ youth, especially on how to be an affirming and safe person to come out to in order to then facilitate effective support around the symptoms being seen. The needs of LGBTQ youth need to be specifically included and spelled out in this proposal as part of the innovation process.

Steve Leoni stated the proposed Link Crew Collaborative was presented as a peer project but it is not a peer project because the word peer implies mutuality. The proposed project trains a group of students to watch out for the other students. That is a professional model, a clinical model. It is also a position of power to some extent. It is too much to entrust that kind of professionalism to students who are just developing.

Tiffany Carter, ACCESS California, NorCal MHA, echoed Smitha Gundavajhala's comments on the proposed Link Crew Collaborative project that the county's data did not indicate that youth were represented in the community planning process. The speaker stated the need for youth to be elevated throughout the entire process of something about them and what is best for them.

Rory O'Brien spoke in support of revising the proposed Link Crew Collaborative project. The speaker suggested giving students one role, compensating them for their time either in salary, stipend, or contribution to a college fund, training them in mental health cross-culturally, and coordinating with Workforce Education and Training (WET) coordinators to turn this into a workforce development program for the county to create a new generation of mental health providers.

Rory O'Brien spoke in support of the PET project and that it be a shorter-term project.

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

The Commission approves Imperial County's Innovation Plan as follows:

Name: Positive Engagement Team (PET)

Amount: $3,120,109

Project Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, and Madrigal-Weiss, and Chair Tamplen.

The following Commissioners voted "No": Commissioners Bunch, Gordon, and Mitchell, and Vice Chair Ashbeck.

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

The Commission approves Imperial County's Innovation Plan as follows:

Name: Positive Engagement Team (PET)

Amount: County to work with staff to determine the amount of funding

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Bunch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Tamplen.

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

ACTION

7: <u>San Bernardino County Innovation Plan</u>

Presenters:

- Veronica Kelley, DSW, LCSW, Director, San Bernardino County Department of Behavioral Health

- Andrew Gruchy, MSW, LCSW, Deputy Director, Community Behavioral Health and Recovery Services
- C. Todd Holder, LCSW, Clinic Supervisor, Recovery Based Engagement & Support Team

Chair Tamplen stated the Commission will consider approval of $17,024,309 to support the San Bernardino County Innovative Remote Onsite Assistance Delivery (InnROADS) Innovation Plan. She asked the representatives from San Bernardino County to present this agenda item.

Veronica Kelley, DSW, LCSW, Director, San Bernardino County Department of Behavioral Health, provided an overview, with a slide presentation, of the need for the proposed innovation project.

Andrew Gruchy, MSW, LCSW, Deputy Director, Community Behavioral Health and Recovery Services, continued the slide presentation and discussed the proposed solution, innovative components, evaluation, budget, and sustainability of the proposed innovation project.

C. Todd Holder, LCSW, Clinic Supervisor, Recovery Based Engagement & Support Team, provided details about the background, process, and effectiveness of the Listen, Empathize, Agree, and Partner (LEAP) model.

Commissioner Questions

Commissioner Gordon stated homelessness is an issue for the whole county, not just behavioral health. He asked who is helping with the problem and what the thinking is about long-term stabilization for the individuals who have been living in encampments.

Ms. Kelley stated there is an active partnership with the Interagency Council on Homelessness and all county departments are at the table. The county is effective because it leverages services for individuals with mental illness. San Bernardino County is a great example for knowing that it is everyone's issue to deal with and leveraging financing to attend to individuals who need services the most.

Commissioner Alvarez asked how the presence of law enforcement is received by individuals in the encampments and how tele-health works in counties without broadband connections.

Mr. Gruchy stated the county is partnering with the sheriff's department. There is an expectation that law enforcement by police action will solve the homeless problem. The county sheriff has made it quite clear that arresting and jailing will not solve the problem. Law enforcement has been thinking about ways to bring social supports, services, and engagement to the homeless population. The hope is that this project will change the perception that homeless individuals may have about law enforcement.

Ms. Kelley stated there are a few cell towers in the county but the bulk of the project is the mobile units that go out to meet the homeless where they are. Nurse practitioners who can provide medication are part of the team since tele-health is not an option.

Commissioner Bunch stated she had to leave to catch her flight but wanted fellow Commissioners to know that she was in support of the proposed innovation plan.

Chair Tamplen asked what makes this project innovative.

Mr. Gruchy stated the mobile treatment team at face value does not sound innovative. Other mental health departments have mobile clinics that set up in parks and other areas where individuals have to come to them. What makes the proposed project innovative is to use off-road vehicles to bring services to where the target population is. The other innovative

component is the multi-agency piece of the engagement team to help individuals start to resolve their housing and homelessness.

Chair Tamplen stated her concern that the peer and family advocates are combined. She asked for clarity on the number of peers with lived experience of homelessness and mental health issues who will be hired. The trust issue with the homeless population is important. She stated when peer and family are combined it is most often family members who are hired because it is less stigmatizing to be a family member. She also stated her concern that the peer and family positions make approximately $20,000 less than other members on the team.

Chair Tamplen stated her concern that the training model and the institute that is doing the training starts off with the generalization that 40 percent of the individuals that will be reached out to who have schizophrenia lack insight. She asked how to assess a lack of insight. That outlook is automatically stigmatizing. Individuals who go through this training will require yet another training to unlearn what they were taught by the Fleet model. She stated the Fleet model also promotes anosognosia when there is no scientific proof of this within the mental health system. The core of the teaching is to label someone as having a lack of insight if they do not agree with the teaching versus trying to understand the reasoning behind the disagreement. She encouraged the county to look into peer-developed training.

Ms. Kelley stated the peer family advocate is the title of the position. She assured that the county is looking for peers who have lived experience with homelessness and mental illness.

Vice Chair Ashbeck stated she continued to struggle with how this program is innovative. She stated this may be a good case study. This is the second county innovation today that goes where the people are. The Commission must do a better job of aggregating projects that sound alike and posting them on the website. She suggested a discussion on that topic on the next meeting agenda.

Mr. Gruchy stated the innovative part is the mobile outreach to where the individuals are as opposed to going to centers within the community. The mobile outreach must find where the homeless encampments are. The innovative part about the multi-agency approach is, by treating the multitude of issues that the agencies treat, it would also increase the engagement with individuals to get them to accept more of the traditional health and housing solutions.

Vice Chair Ashbeck stated housing is not part of this project.

Mr. Gruchy stated it is not a direct measurement but the materials mention housing. The county has access to 150 shelter beds and other housing options that do not require this funding to access them. It is the engagement part to address the needs of this population and bring them into those services already in place.

Ms. Kelley stated taking psychiatric care into the Mojave Desert or forests is not something that is done every day but it is needed.

Commissioner Mitchell asked what the consultant will be doing to earn the $100,000.

Mr. Gruchy stated there is more than one consultant. The county will work with veterinary groups, humane societies, and other individuals who could bring other services to the homeless population.

Chair Tamplen stated the Commission received a letter stating there was not enough stakeholder input into the development of the proposed project. She asked how the county will address this.

Ms. Kelley stated the county cares about stakeholder involvement and has policies and procedures that address having a monthly stakeholder process. She asked Michelle Dusick to further explain the stakeholder process.

Michelle Dusick, MHSA Coordinator, San Bernardino County Department of Behavioral Health, stated the county holds 20 ongoing stakeholder meetings monthly with different groups of stakeholders.

Public Comment

Robb Layne spoke in support of the proposed project.

Ricardo Sainz-Ayon spoke in support of the proposed project.

Adrienne Shilton spoke in support of the proposed project.

Sharon Nevins, Director, San Bernardino County Aging and Adult Services, spoke in support of the proposed project.

Poshi Walker spoke in support of the proposed project.

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

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

Name: Innovative Remote Onsite Assistance Delivery (InnROADS)

Amount: $17,024,309

Project Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Gordon, Madrigal-Weiss, and Mitchell, and Vice Chair Ashbeck and Chair Tamplen.

INFORMATION

8: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director

Chair Tamplen tabled this agenda item to the next Commission meeting.

GENERAL PUBLIC COMMENT

Stacie Hiramoto stated this comment was meant to go under the strategic planning agenda item. The speaker echoed and supported the comments of Poshi Walker and Rory O'Brien regarding thinking about either the structure of meetings or decision-making as part of the strategic planning project. Something is not working with the structure when there are only four Commissioners left at the end of the meeting and there was a proposal to make a significant change to an RFP that was already released and the public did not know about until less than one week prior to this meeting. All comments given in the meeting and in letters sent to the Commission opposed the option which was passed today.

ADJOURN

There being no further business, the meeting was adjourned at 4:45 p.m.

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AGENDA ITEM 2

Action

March 28, 2019 Commission Meeting

Mono County Innovation Plan Extension

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Mono County's request for additional time and funds to support the following previously approved Innovative project:

(A) **Eastern Sierra Strengths-Based Learning Collaborative (ESSBLC): $84,935-EXTENSION**

- In 2017, Mono County received approval of $259,046 for an Innovation project to develop a regional collaborative with the neighboring Counties of Inyo and Alpine as well as the following community partners: Mammoth Hospital, law enforcement, and the Wild Iris Crisis and Counseling Center. The collaborative focused on training County staff and partners on the Strengths Model, developed by the University of Kansas School of Social Welfare through nine (9) sessions facilitated by an expert trainer/coach from the California Institute for Behavioral Health Solutions (CIBHS) over a period of 18 months. The goal was to develop skills for staff in order to provide improved services to clients, prevent staff burn out and integrate the best practice in the three counties.

- Due to initial lack of staff engagement with the model and challenges with consistency from community partners involved in trainings, where staff must travel to other counties, additional time and money are needed.

- Mono County is proposing an extension of 4 months for more in-person, 1:1 time with facilitators and is requesting additional funds in the amount of $84,935 (an increase of 32%) for the additional training time and for a more qualitative evaluation in order to complete the project.

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.

Presenters for Mono County's Innovation Project:

- Robin K. Roberts, MFT, Mono County Behavioral Health Director
- Dr. Rick Goscha, Sr. Vice President, California Institute for Behavioral Health Solutions

Enclosures (3): (1) Biographies for Mono County's Innovation Presenters; (2) ESSBLC Staff Analysis; (3) ESSBLC 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 Commission website at the following URL:

http://mhsoac.ca.gov/document/2019-03/mono-county-innovation-project-extension-request-march-28-2019

Proposed Motion: The Commission approves Mono County's request for $84,935 additional funding and extension of time as follows:

Name: Eastern Sierra Strengths-Based Learning Collaborative (ESSBLC)

Additional Amount: $84,935 for a total INN project budget of $343,981

Additional Project Length: Four (4) months for a total project duration of 28 months.

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Mental Health Services
Oversight & Accountability Commission

Biographies for Mono County Presenters

Robin K. Roberts, MFT

Robin K. Roberts has served as the Director of Mono County Behavioral Health since 2012. She is also the co-chair of the CBHDA Small Counties Committee.

Dr. Rick Goscha

Dr. Rick Goscha is Sr. Vice President for the California Institute for Behavioral Health Solutions. Dr. Goscha previously worked as the Director for the University of Kansas Center for Mental Health Research and Innovation, recognized nationally and internationally for their work around the Strengths Model and other recovery-oriented, evidence-based practices for people with serious mental illnesses.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – MONO COUNTY

Innovative (INN) Project Name:	**Eastern Sierra Strengths-Based Learning Collaborative: Extension Request**
Extension Funding Requested for Project:	**$84,935**

Review History:

MHSOAC Original Approval Date:	September 28, 2017
• Original Program Dates:	10/01/2017 through 09/30/2019 (Two Years)
• New Program Dates:	10/1/2019 through 01/30/2020
• New Budget:	$84,935
Approved by the BOS:	January 8, 2019
County Submitted Innovation (INN) Project:	January 17, 2019
MHSOAC Consideration of INN Project:	March 28, 2019

Project Introduction:

In 2017, Mono County received approval of $259,046 for an innovation project to develop a regional collaborative with the neighboring Counties of Inyo and Alpine as well as the following community partners: Mammoth Hospital, law enforcement, and the Wild Iris Crisis and Counseling Center. The collaborative focused on training County staff and partners on the Strengths Model, developed by the University of Kansas School of Social Welfare through nine sessions facilitated by an expert trainer/coach from the California Institute for Behavioral Health Solutions (CIBHS) over a period of 18 months. The goal was to develop skills for staff in order to provide improved services to clients, prevent staff burn out and integrate the best practice in the three counties.

Due to initial lack of staff engagement with the model and challenges with consistency from community partners involved in trainings where staff must travel to other counties, additional time and money are needed.

Mono County is proposing an extension of 4 months for more in-person time with facilitators and is requesting additional funds in the amount of $84,935 (an increase of 32%) for the additional training time and for a more qualitative evaluation in order to complete the project.

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

The Need

During the first year of this innovation plan, Mono County Behavioral Health (MCBH) followed the approved timeline and launched the first learning sessions for the Eastern Sierra Learning Collaborative. While the County reports that the project is resulting in increased collaboration between the three county departments and states that staff report the Strengths Model is having a positive impact on their work with clients, two significant barriers have arisen. First, the County identified an initial lack of staff engagement with the Strengths Model due to the supervision of the implementation being too much for one supervisor. The County shifted to identify several “Strengths Model Champions” to support the implementation but this caused delays. Secondly, the County overestimated the amount of time the community partners could spend traveling to attend trainings. Due to the need for consistent attendance as content builds from training to training, the County had to rethink the training strategy.

The Response

To address these barriers, County staff (the project stakeholders) and the Strengths Model facilitators have proposed an extension to the services outlined in the original innovation plan, including more one-on-one coaching with staff, additional training in Motivational Interviewing techniques, more in-person time in Mono County for facilitators to engage with and train community partners, and additional funds for more qualitative evaluation including exploring two additional learning questions.

(1) how will community partners benefit from in-person tailored training; and (2) will additional Motivational Interviewing training and on-on-one coaching help build staff capacity in Mono County

An important part of the original innovation proposal is the creation of a cross-county collaboration template/checklist, lessons learned fact sheets, and a feasibility checklist/readiness assessment. The extension request will allow the County to address

additional learning questions and further inform the collaboration and feasibility checklists resulting in a more useful tool for dissemination.

In addition, the County initiated this project to overhaul their service delivery model by continuing to integrate successes from the project into day to day services. The County never intended to need a sustainability model only a plan to disseminate learning and share tools. With this in mind, **the Commission may wish to ask the County to discuss how they will address future staff turnover and fund the onboarding of new staff in this model.**

The Community Program Planning (CPP) Process

The CPP for this extension was formally conducted as part of the County's Annual Innovation Project Report and also conducted as an ongoing part of the project itself. Comments and discussions shared by County staff and the evaluation workgroup about project improvement, combined with observations by the consultant, led to the extension request. Specifically, it was determined that the County would need to request additional time and funding to complete the training aspect of the project and finish a robust evaluation.

The County completed a 30 day public comment period on December 18, 2018, held a MHB hearing and received BOS approval in January 2019.

This extension request was shared with Commission stakeholders on October 11, 2018 and no comments were received in response.

Learning Objectives and Evaluation

As part of their extension request, Mono County has proposed broadening their qualitative evaluation of the collaborative to better understand the effect of additional coaching and training on engagement with community partners. To guide this inquiry, the County has included two additional learning goals, and include: (1) how will community partners benefit from in-person tailored training; and (2) will additional Motivational Interviewing training and on-on-one coaching help build staff capacity in Mono County?

Measures that will be used to evaluate the program remain the same, and are appropriate to meet the learning goals of the project (**page 43 of the County plan**). Interviews and focus groups will continue to be conducted with staff and key stakeholders during the remainder of the project as well as during a debriefing at the conclusion of the project. The deliverables from the project remain the same, and consist of a cross-county collaboration template/checklist, lessons learned fact sheets, and a feasibility checklist/readiness assessment. All methods, measures, and deliverables are sufficient to meeting the primary purpose of the project to "promote interagency collaboration related to mental health services, supports, or outcomes."

The additional time to build out the project, including the addition of two learning goals appears appropriate, however, there is room for further evaluation. While the County mentions that they will be tracking outcomes of the Strengths Model and that the training impacts client outcomes, it still remains outside the scope of the current innovation plan.

With this in mind, **the County may wish to discuss any future efforts for evaluation relative to staff knowledge and client outcomes.**

The evaluation, including data collection and analysis, as well as the development of the deliverables will be conducted by the Mono County Behavioral Health MHSA coordinator and California Institute for Behavioral Health Solutions facilitators. At the conclusion of their project, findings and tools/deliverables will be shared with stakeholders within all participating counties.

The Budget

Mono County requests an additional $84,935 of innovation funds to fund personnel and consultants for an additional 4 months. The breakdown is as follows:

Salaries for the Executive Leader, Team Supervisor/Data Lead, Clinical Supervisor and Direct Service Providers in the amount of $29,935 represent 35% of the total cost;

Consultant costs (CIBHS) for training and evaluation in the amount of $55,000 represent 65% of the total cost;

Outcomes Tracking and Evaluation will continue to be completed by the consulting CIBHS Contractors as well as Mono County's Data Lead.

While it could be argued that the contractor has an interest in extending the training period in Mono County, it is important to consider the input of the evaluation workgroup and the benefit to completing the training as intended for the original target populations (County staff and community partners).

Additional Regulatory Requirements

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

References

none

Full project proposal can be accessed here: http://mhsoac.ca.gov/document/2019-03/mono-county-innovation-project-extension-request-march-28-2019

Mono County FY 18-19 Innovation Plan Extension Request Brief

MHSOAC Commission Meeting: March 28, 2019

Name of County: Mono County

Name of Innovation (INN) Project:

Eastern Sierra Strengths-Based Learning Collaborative: Extension Request

Original INN Funding Requested for Project: $259,046 | **Duration of INN Project:** 24 months

Additional INN Funding Requested for Project Extension: $84,935 **| Additional time:** 28 months

Brief Introduction to INN Project & Extension

In its original INN project plan, Mono County Behavioral Health (MCBH) proposed to develop a regional collaborative with the neighboring Counties of Inyo and Alpine, as well as several community partners. Over the last 14 months, the Collaborative has focused on training County staff and partners on the Strengths Model, which was developed by the University of Kansas School of Social Welfare. Learning sessions have been facilitated by an expert trainer/coach from the California Institute for Behavioral Health Solutions (CIBHS) to assist in skill development for staff. This skill development is intended to provide improved services to clients, prevent staff burn out, and integrate the best practice in the three counties. Through this partnership, MCBH has learned lessons around how to implement a successful collaborative among three of the smallest counties, improve client outcomes, and how the lessons learned might be applied in other counties.

This INN project has been successful thus far and has contributed to increased collaboration between the three county departments, including sharing of information about processes, programs, and practices. Staff in Mono County have implemented the weekly Strengths Model Group Supervision and many staff are using Strengths Assessments and Personal Recovery Plans (two of the key tools in the Strengths Model). Despite these early successes, MCBH staff (the project stakeholders) and the project consultants have identified areas where implementation could be bolstered by additional support. Diving into the project has also challenged MCBH staff and project consultants to consider several additional learning questions. This extension request includes the proposed solutions to bolster implementation and address these additional learning questions.

Project Aims/Learning Questions

1. To learn or better understand how to facilitate cross-county and inter-agency collaboration.

2. To learn or better understand what factors serve as facilitators or barriers to cross-county collaboration.
3. To learn or better understand the benefits of such a collaboration in remote, rural environments.
4. To explore how community partners may benefit from in-person, tailored training on the Strengths Model.
5. To explore how tailored skill development such as motivational interview training and one-on-one coaching will help build staff capacity.

Summary of the Problem/Need

Mono County Behavioral Health (MCBH) has identified several problems/needs that warrant an extension of this INN project. Within several months of launching this Innovation project, MCBH realized that supervising the local implementation of this project was an unrealistic workload for one supervisor. A solution for this problem – identifying "Strengths Model Champions" among other staff – took time to develop and refine, placing MCBH a bit behind the implementation curve. Furthermore, MCBH staff "wear many hats," which we believe has made our learning process a little slower than you might see in a larger, more specialized department. MCBH encountered a second critical hurdle related to involving its community partners. Although MCBH worked with community partners in preparing for this Innovation Project, the department overestimated the ability and time for community partners to travel to and attend these trainings. MCBH wants to ensure that this innovative component of the collaborative is successfully achieved.

Components of the Extension & Rationale

1. One-on-One Coaching & Motivational Interview (MI) Training
    - The one-on-one coaching and additional MI Training would help provide additional support to staff who are serving as the "project champions" and ensure that other staff have an opportunity to hone their Strengths Model skills with the help of experts.
2. Training for Community Partners
    - Adding more in-person time in Mono County for facilitators to engage with and train community partners will help alleviate the challenges around time and travel that have come up since implementation. It will also allow the facilitators to tailor the content specifically to the partners attending and break the Strengths Model down appropriately.
3. Additional Qualitative Evaluation

- Adding additional funding for qualitative evaluation will not only allow facilitators to study how community partners may benefit from in-person tailored training, but will also provide further information on how the collaborative was locally implemented and what lessons can be learned from a staff perspective to help answer the original learning questions.

Summary of the Evaluation Plan:

MCBH has primarily used a process evaluation to track the implementation of the Eastern Sierra Strengths Based Learning Collaborative. The MCBH MHSA Coordinator and CIBHS facilitators have shared responsibility for tracking all activities and outputs and they will be compiling this information into the project deliverables (templates, check list, and toolkit) in the coming months. This evaluation has also included focus groups and interviews with stakeholders, including both staff participating in the Collaborative and clients in the individual departments. As mentioned above, additional evaluation funding will allow for exploration of the two new learning questions added as part of this extension. These results will be disseminated to local and state stakeholders.

Budget by Fiscal Year and Category

Extension Expenditures	**FY 18/19**	**FY 19/20**	**Total**
Personnel Costs: Salaries		$29,935	$29,935
Direct Costs: Consultants	$20,000	$35,000	$55,000
Total Innovation Budget	$20,000	$64,935	$84,935

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AGENDA ITEM 3

Action

March 28, 2019 Commission Meeting

San Mateo County Innovation Plan Extension

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of San Mateo County's request for additional time and funds to support the following Innovative project:

(A) **LGBTQ Behavioral Health Coordinated Services (The Pride Center): $1,550,000-EXTENSION**

- On July 28, 2016, San Mateo County received approval of $2,200,000 for a 3 year Innovation project to establish The Pride Center in order to provide a coordinated approach across clinical services, psychoeducational and community/social events and resources for the LGBTQ+ community. It is a formal collaboration of community-based organizations.
- The collaboration experienced contracting and implementation delays in addition to serving twice as many clients in the first year than originally planned. These challenges required an adjustment of the original timeline and the addition of new assessment tools to aid the evaluation. In response, San Mateo County is requesting additional funds in the amount of $1,550,000 (an increase of 70%) and two more years in order to complete the project and accomplish the following goals:

  1) Strengthen internal and external collaboration efforts to be able to demonstrate with more certainty whether the coordinated service approach improves service delivery;
  2) Measure clinical outcomes of clients with severe mental illness (SMI), specifically improved mental health indicators for individuals who might not otherwise have accessed clinical services and/or received quality, culturally responsive care;
  3) Develop a replicable best practice model to share statewide and nationally, if the evaluation continues to demonstrate that the coordinated service approach improves health outcomes and access for LGBTQ+.

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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.

Presenters for San Mateo County's Innovation Project:

- Dave Pine, Supervisor, San Mateo County, District 1
- Lisa Putkey, MA, Program Director, San Mateo County Pride Center
- Andres Loyola, Peer Support Worker, San Mateo County Pride Center
- Ryan Fukumori, PhD, Research Associate, Resource Development Associates
- Scott Gilman, MSA, CBHE, Director, San Mateo County Health, Behavioral Health and Recovery Services

Enclosures (2): (1) Biographies for San Mateo County's Innovation Presenters; (2) The Pride Center 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 Commission website at the following URL:

http://mhsoac.ca.gov/document/2019-03/san-mateo-county-pride-center-innovation-plan-march-28-2019

Proposed Motion: The Commission approves San Mateo County's request for $1,550,000 additional funding and extension of time as follows:

Name: LGBTQ Behavioral Health Coordinated Services (The Pride Center)

Additional Amount: $1,550,000 for a total INN project budget of $3,750,000

Additional Project Length: Two (2) years for a total project duration of five (5) years.

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San Mateo County MHSA Innovation Extension Request – The Pride Center
March 28, 2019 MHSOAC Meeting

Speaker Names and Bios

Dave Pine (he/him/his), Supervisor
San Mateo County Board of Supervisors
dpine@smcgov.org / (650) 363-4571

Dave Pine was first elected to the San Mateo County Board of Supervisors to represent District 1 in a special election in May 2011 and has served as Board President in 2014 and in 2018. He is the Board of Supervisors liaison to both the County's Mental Health & Substance Abuse Recovery Commission and LGBTQ Commission, which he helped found, and a member of the MHSA Steering Committee.

Lisa Putkey, MA (they/them/theirs, she/her/hers), Program Director
San Mateo County Pride Center
lisa.putkey@sanmateopride.org / (650) 591-0133 ext. 150

Lisa Putkey is excited to be back in her home county working for the health and wellbeing of fellow LGBTQ+ community as the Program Director of the San Mateo County Pride Center. She has previously worked as a Peace Studies teacher, program administrator, community organizer, youth program coordinator, and union representative.

Andres Loyola (they/them/theirs or she/her/hers), Peer Support Worker
San Mateo County Pride Center
andres.loyola@sanmateopride.org / (650) 591-0133 ext. 151

Andres Loyola is a proud Bay Area Native from the city of Oakland, CA and the Peer Support Worker here with the San Mateo County Pride Center. In this role, Andres provides knowledge and experience, and emotional, social and practical support to clients and program participants.

Ryan Fukumori, PhD (he/him/his), Research Associate
Resource Development Associates
rfukumori@resourcedevelopment.net / (510) 488-4345

Ryan Fukumori has an extensive background in interdisciplinary research regarding communities of color in California. As a Research Associate at Resource Development Associates (RDA), Ryan serves on the San Mateo County MHSA Innovation Evaluation team for the San Mateo County Pride Center and the Health Ambassador Program-Youth (HAP-Y).

Scott Gilman, MSA, CBHE (he/him/his), Director
San Mateo County Health, Behavioral Health and Recovery Services
sgilman@smcgov.org (650) 573-2748

Scott Gilman joined San Mateo County as the new Behavioral Health and Recovery Services (BHRS) Director earlier this year. Over the past five years, he served as Chief Executive Officer of Network180, the Community Mental Health Center for Kent County, which similar to San Mateo County BHRS, Network 180 provides direct mental health and substance use services and maintains a large private provider network.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – SAN MATEO COUNTY

Innovative (INN) Project Name:	**LGBTQ Behavioral Health Coordinated Services (The Pride Center)**
Extension Funding Requested for Project:	**$1,550,000**

Review History:

MHSOAC Original Approval Date:	July 28, 2016
• Original Program Duration:	Three Years
• Original Budget:	$2,200,000
• Rollover of unspent funds:	$220,000
• New Program Dates:	Two Years (Total of Five Years)
• New Budget:	$1,550,000 (Total of $3,750,000)
Approved by the Board of Supervisors:	February 26, 2019
County Submitted INN Project:	February 12, 2019
MHSOAC Consideration of INN Project:	March 28, 2019

Project Introduction:

On July 28, 2016, San Mateo County received approval of $2,200,000 for a 3 year innovation project to establish The Pride Center in order to provide a coordinated approach across clinical services, psychoeducational and community/social events and resources for the LGBTQ+ community. It is a formal collaboration of community-based organizations.

While the Commission approved the original project, the Commission also indicated that it expected the County to amend its plan in order to provide funding for evaluation.

The County's extension request addresses both that expectation for an amendment to provide for evaluation funding and a request to extend the length of the service component of the project.

In the first year of the project, the collaboration experienced contracting and implementation delays in addition to serving twice as many clients than originally planned. These challenges required an adjustment of the original timeline and the addition of new

assessment tools to aid the evaluation. In response, San Mateo County is requesting additional funds in the amount of $1,550,000 (an increase of 70%) and two more years in order to complete the project and accomplish the following goals:

1) Strengthen internal and external collaboration efforts to be able to demonstrate with more certainty whether the coordinated service approach improves service delivery; 2) Measure clinical outcomes of clients with severe mental illness (SMI), specifically improved mental health indicators for individuals who might not otherwise have accessed clinical services and/or received quality, culturally responsive care; 3) Develop a replicable best practice model to share statewide and nationally, if the evaluation continues to demonstrate that the coordinated service approach improves health outcomes and access for LGBTQ+.

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

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

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

The Need

During the first two years of this Innovation plan, the collaboration encountered and overcame barriers such as: lack of LGBTQ+ friendly infrastructure and trained staff; overwhelming need (twice as many clients served in first year than expected); and contracting delays which contributed to an initial delay in implementation and the subsequent adjustment of the timeline.

In addition, the County presents data from a survey confirming the ongoing need for LGBTQ+ friendly mental health outreach and services with 32.4% of adult respondents stating that they did not seek services because they could not find a LGBTQ-friendly provider.

The Response

After two years the collaborative has made significant progress to accomplish the original outcomes highlighted in their original proposal. Examples of accomplishments include:

- Established a Community Advisory Board and Youth Advisory Board
- Launched a youth program, an older adult program and supportive social/cultural and educational community events and activities
- Developed clinical program - counseling, peer support and case management and referral system including Medi-Cal and sliding scale fee for service
- Established as a drop-in center and gender and name change clinic
- Active consultation with mental health providers, schools and community agencies seeking support in working with LGBTQ+
- Development of a training program for behavioral health providers, schools and other agencies
- Establishment of a resource library, computer lab, a volunteer program and a resource hub for LGBTQ+ affirming

However, due to barriers outlined previously, the collaboration is requesting additional time and funds to continue delivering services through the new model and complete the required evaluation to determine if improved service delivery leads to improved client outcomes.

The collaboration intends to accomplish the following activities during the extension period:

- Establishment of a trainee program to allow trainees to see Medi-Cal clients who live with a serious mental illness and provide pathways for queer and trans clinicians of color
- Strengthen the training and consultation program to support mental health providers working with LGBTQ+ clients
- Implement a monthly consultation group for regional providers
- Implement a best practice model of collaboration to strengthen the innovative coordinated service approach of the Pride Center
- Collect outcome data for improved behavioral health indicators of clients
- Develop a replicable best practice model to share statewide and nationally in order to demonstrate the coordinated service approach to improve health outcomes and access for LGBTQ+
- Enhance the Peer Support Program by training and certifying peer support specialists
- Increase collaboration with Bay Area, Statewide and national LGBTQ+ networks
- Transition into the role of lead organizer for the annual Pride Celebration, a community defined practice reducing disparities
- Develop eHealth services to better support clients with access barriers.

The Community Program Planning (CPP) Process

San Mateo County presents ample evidence of a robust CPP process prior to requesting this extension (see page 10 and appendix D of the full plan).

San Mateo County is advised by an MHSA Steering Committee made up of 40 community leaders including their mental health board. After being presented with the

accomplishments of the Pride Center, evaluation outcomes and need for an extension, the Steering Committee members unanimously voted for the recommendation to request a 2-year extension.

This extension request was shared with Commission stakeholders on February 13, 2019 and no comments were received in response.

Learning Objectives and Evaluation

San Mateo County seeks to continue and build upon their original evaluation plan by including standardized tools to measure client outcomes. Doing so would allow the County to delve further into understanding the service delivery component of their project by determining if improved service delivery leads to improved client outcomes. The County's primary purposes remain to "increase access to services to underserved groups," and "promote interagency collaboration related to mental health services, supports, or outcomes." The County's target population has not changed, and will remain those with high risk for serious mental illness within the LGBTQ and gender non-conforming/variant community. Given the response to services to date, **the County may wish to provide the Commission with an updated number of clients they expect to serve though the remainder of their project**.

The three learnings goals of the project remain the same, and seek to determine the extent to which the program is implemented as planned, the extent to which the Pride Center improves access to services, and the extent to which clients receiving services see improved behavioral health outcomes (**see pg. 1 of evaluation addendum**).

Measures and indicators that will be used to evaluate the program are appropriate to meet the learning goals and outcomes of the project, and are laid out on **pages 2-3 of the evaluation addendum**. Specifically, to extend their evaluation, the County has added the inclusion of assessments to measure client outcomes (Adult Needs and Strengths Assessment; Child and Adolescent Needs and Strengths). Additionally, the County will collect qualitative data to better understand the challenges faced by clients and their experiences with the program.

In order to gather the information necessary for evaluation, the County will collect data from several sources, including: participant surveys, focus groups, quarterly progress reports, as well as client assessment data (**see pgs. 2-3 of evaluation addendum**). San Mateo County will use both quantitative and qualitative methods to evaluate their program; baseline information will be gathered through results from the ANSA and CANS assessments, as well as other client information from electronic health records.

The additions to the County's evaluation plan are important to the overall evaluation of the project and to determine if the project can become a replicable best practice. While the evaluation plan is sufficient to meet the primary purposes and learning goals of the project, **the evaluation may benefit from the inclusion of additional measures relative to trainings provided to clinicians**. In particular, it would be useful to include measures around clinical training received, increases in knowledge, as well as ongoing

supervision, to provide further insight into the effectiveness of improving competency among clinicians in working with the target population.

The County will enter into a contract with an outside evaluator to oversee the evaluation, and complete the final evaluation report. At the conclusion of their project, San Mateo County will present findings internally thorough the Behavioral Health and Recovery Services MHSA webpage, as well as to local stakeholders.

The Budget

San Mateo County is requesting a two-year MHSA Innovation extension for the Pride Center in the amount of $1,550,000 ($700,000 per year for services; $150,000 for evaluation and development of a replicable tool). All innovation funds will be contracted out to the existing partners. The county will also be utilizing $220,000 of unspent funds from the original approval.

The extension request is in line with the original plan allocations of approximately $733,000 per year to accomplish the goals of The Pride Center. The County, contractors and community report no issues with the budget projections, only need for more time to fully operationalize, test and evaluate the project.

While the request for additional funds is substantial (an increase of 70%), the County and associated contractor has demonstrated that they are making progress on the goals of the project, have added additional value with the extension request and continue to leverage the innovation investment to bring in other funds to create a sustainable program.

An argument could be made that the County could utilize funding sources identified in their original sustainability plan to continue services however, the further investment of innovation dollars to finish the data collection and evaluation of this project is in line with the intent of the MHSA and will contribute to statewide learning.

Highlights from the collaborative sustainability efforts:

- Kaiser Permanente awarded $90k to the San Mateo County Pride Center to reduce stigma around mental health and increase LGBTQ+ visibility on the Peninsula through education, outreach, and community building.
- Request for Proposals asked for a sustainability plan that identified diversified revenue sources including Medi-Cal billing, local government, including MHSA, grants and private donors.
- Pride Center hired a full-time grant writer (not funded with innovation).

Additional Regulatory Requirements

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

References

https://lgbtq.smcgov.org/2017-2018-survey-information

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2019-03/san-mateo-county-pride-center-innovation-plan-march-28-2019

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AGENDA ITEM 4

Action

March 28, 2019 Commission Meeting

Tulare County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Tulare County's request to fund two new innovative projects:

(A) **Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication: $1,610,734**

Tulare County proposes to assess and address Metabolic Syndrome in individuals who are treated with injectable antipsychotic medications by working collaboratively with Tulare County's Visalia Adult Integrated Clinic and employees from the County Health Department.

(B) **Connectedness 2 Community: $ 1,320,684**

Tulare County Behavioral Health proposes to develop a collaborative relationship with local mental health providers and community leaders in an effort to incorporate consumer's cultural values and spiritual beliefs into an individual's treatment plan.

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.

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Presenters for Tulare County's Innovation Projects:

Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication:

- Alisa Huff, PsyD, Lead Psychologist
- Lester Love, M.D., Medical Director
- Sander Valyocsik, M.A., Consultant, Societas, Inc.

Connectedness 2 Community

- Carol Davies, Consultant, Davies and Associates, Inc,
- Michele Cruz, MHSA Manager

Enclosures (5): (1) Biographies for Tulare County's Innovation Presenters; (2) Staff Analysis: Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication; (3) Project Brief: Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication; (4) Staff Analysis: Connectedness 2 Community; (5) Project Brief: Connectedness 2 Community

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

Additional Materials (2): A link to the County's Innovation Plans are available on the Commission website at the following URL:

Metabolic Syndrome: http://mhsoac.ca.gov/document/2019-03/tulare-county-addressing-metabolic-syndrome-pilot-project-march-28-2019

Connectedness 2 Community: http://mhsoac.ca.gov/document/2019-03/tulare-county-connectedness-2-community-march-28-2019

Proposed Motions: The Commission approves Tulare County's Innovation plans, as follows:

Name:	Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication
Amount:	$1,610,734
Project Length:	Five (5) Years

Name:	Connectedness 2 Community
Amount:	$1,320,684
Project Length:	Five (5) Years

TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Timothy Durick, Psy.D. • Director • Mental Health Branch

Timothy W. Lutz, MBA
Agency Director

Mental Health Services Act (MHSA) – Innovation Project Presenters

Project: Metabolic Syndrome Pilot Project

Lester Love, M.D., Medical Director – Born and raised in Chicago, Dr. Love completed his undergraduate degree at the University of Chicago, and then completed his advanced degrees at the University of California, San Francisco, including medical school, Family Medicine Residency and Psychiatry Residency. It is through this lens that he champions healing the whole person.

Alisa L. Huff, Psy. D., Lead Psychologist – Dr. Huff has been pivotal in advancing efforts within the Mental Health Branch toward integration with physical health care, working in the earlier Innovation program for Tulare County, the Integrated Health Pod, which introduced mental health consultations within the county health clinic. Now based at the Visalia Adult Integrated Clinic, Dr. Huff will have additional oversight of the Metabolic Syndrome Pilot Project.

Sander Valyocsik, M.A., Consultant, Societas, Inc. – Mr. Valyocsik has worked as a program evaluator and grant writer in the San Joaquin Valley for 20 years. He is most active in the fields of mental health and alcohol and other drug use prevention.

Project: Connectedness 2 Community

Michele R. Cruz, MHSA Manager – Ms. Cruz has been in her role as MHSA Manager just over three years, overseeing the various components within MHSA, including Innovation. This has included oversight of the stakeholder meetings and development of the draft program in collaboration with Ms. Davies and the MHSA Team.

Carol Davies, Consultant, Davies and Associates, Inc. – Ms. Davies has served as a regional convener and strategic planner for over 30 years. Her contribution to this project has been a set of external eyes and ears to support development of strategies that reflect desires of stakeholders, align with MHSA mission, and are built around sustainable practices.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— TULARE COUNTY

Innovation (INN) Project Name:	**Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication**
Total INN Funding Requested:	**$1,610,734**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	May 22, 2018
County submitted INN Project:	February 4, 2019
MHSOAC consideration of INN Project:	March 28, 2019

Project Introduction:

Tulare County comes before the Commission for their first time to propose and address Metabolic Syndrome in individuals who are treated with injectable antipsychotic medications by working collaboratively with Tulare County's Visalia Adult Integrated Clinic and employees from the County Health Department.

Metabolic Syndrome is not a disease itself, but rather a group of risk factors that may lead to high blood pressure, high blood sugar, and unhealthy cholesterol levels. These risk factors can lead to heart disease, heart attacks, strokes, and diabetes (Khatri, 2017). Research supports that individuals who receive injectable antipsychotic medications to treat their psychosis may experience side effects due to these medications, which may result in untreated components of metabolic syndrome such as high cholesterol, weight gain, and diabetes (Goldberg, 2018).

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

The County states this innovation project meets the primary purpose of promoting interagency collaboration related to mental health services, supports, or outcomes by introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

The Need

Tulare County states there is a large rate of metabolic syndrome among mental health consumers residing in their County. Between 2013 and 2014, a total of 214 individuals had been admitted into the County's psychiatric hospitals. Of that number, only 2.4% (n=5) had ever been assessed for metabolic syndrome. The County feels an opportunity is being missed to better serve those mental health consumers by assessing and treating the side effects that are caused by their antipsychotic medication.

The County states metabolic syndrome affects between 20-68% of those who have schizophrenia, depending on the screening criteria used. For those who have bipolar disorder, those with metabolic syndrome ranges between 25-50%; and 42% of those who have been diagnosed with schizoaffective disorder may have metabolic syndrome. Research supports there is a high prevalence of metabolic syndrome in those with schizophrenia and women are especially at risk of cardiovascular disease as a result of antipsychotic injectable medications (McEvoy, et al. 2005).

The County has made previous efforts to bring aspects of mental health and physical health together to make treatment more holistic. The County has implemented two (2) previous programs to address both physical and mental health. The Older Adult Hopelessness Screening (OAHS) Program began in 2011 and was funded with MHSA Prevention and Early Intervention funds. The goal of this project was to identify suicide risk in older adults, utilizing the Beck Depression Scale, when they visited their primary care doctor in the county health care center. This project proved to be successful and the County states the program was adopted by the Suicide Prevention Resource Center in 2013 as a promising practice. Their second project, the Physical Health and Mental Health Integration Program, began in 2012 utilizing innovation funds and is now sustained with Community Services and Supports funds. The purpose of that project was to streamline service delivery between the physical health system and mental health system. This project resulted in a 171% increase in referrals from the health care center to receive mental health services.

Although both of these projects have proven to be successful in Tulare County, neither of these two (2) projects have previously addressed the correlation between Metabolic Syndrome and individuals who take injectable antipsychotic medications. Due to the success the County states they have had with treating an individual holistically (with both physical and mental health), the County hopes to learn if they can improve the quality of life of mental health consumers who take injectable antipsychotic medications that may have developed risk factors associated with Metabolic Syndrome. The County states this project differs than their previous projects which integrate physical and mental health in that they have never focused on mental health consumers who have, or are at risk for, metabolic syndrome. The County researched other programs relating to metabolic syndrome (**see pgs 11-14 of County plan**) and concluded that the programs the County researched did not contain pharmacological components to address metabolic syndrome.

The Response

The County hopes to assess and follow mental health consumers who receive injectable antipsychotic medications, and who are at risk for metabolic syndrome, and will work collaboratively with the mental health care center and the health care clinic to reduce the symptoms of this condition.

Tulare County will select (*have selected*) mental health consumers from the Visalia Adult Integrated Clinic (VAIC) who take injectable antipsychotic medications for their psychosis and will be required to complete consent and release of information forms to participate in this voluntary program. Of the 120 consumers who currently receive injectable antipsychotic medications at VAIC, this project will serve approximately 60 of them. Because those who have a mental illness are more prone to be at risk of metabolic syndrome, those who receive injectable antipsychotic medications are at even greater risk of factors associated with the condition.

Participants for this project will be assessed on a quarterly basis upon visiting VAIC for their normally scheduled mental health appointment by a licensed medical provider and a medical assistant, employed with the County's Visalia Health Care Center (VHCC). Participants will be assessed for their knowledge of metabolic syndrome and its associated risks. The assessment will be discussed with a Nurse Health Educator (Public Health Nurse). Participants will be screened for risks associated with the disease (**for the specific medical screening criteria of metabolic syndrome, see pgs 16-17 of County plan**).

If examination results in risks associated with metabolic syndrome, the results will be electronically transmitted to the participant's primary care doctor and licensed psychiatric provider via the County's electronic health system. In the event the participant does not have a County primary care doctor, their primary care doctor will be contacted (release of information form will have already been signed as part of enrollment in project).

The Nurse Health Educator will work quarterly with participants to create a treatment plan to incorporate healthy habits, which may include gym memberships and referrals to other services. If the Nurse believes the participant may have a substance use problem with alcohol and/or drugs, appropriate referrals will be made. To ensure the participant

succeeds in obtaining their personal lifestyle goals, a team of specialists (psychiatrists, nurses, peer support specialists, case managers and therapists) will check in with them periodically to assist towards participant's meeting their progress.

Tulare County states an Institutional Review Board approval is not needed as this project is not a research study; rather, this project involves the collaboration of mental health and health care providers to address risks associated with metabolic syndrome.

Background Information

This project was brought forward to Commission staff in December 2017. The technical and consultative process began in order to prepare the County for presenting this project to the Commission. Consultative calls were held with the County regarding this project in January 2018 and again in December 2018. During the call in December 2018, Commission staff made an inquiry of their timeline because it appeared as if participants may have already been selected for the project. The County then disclosed that due to the sense of urgency for this project, they had selected participants and had implemented this project, utilizing Community Support and Services (CSS) funds in April 2018. **Commission staff advised the County that since the program had already been implemented, County cannot seek innovation funding for a currently implemented program and in order to use Innovation funds, the County would need to add or modify elements to meet innovation criteria, and indicate what they hoped to learn by adding these elements.**

The County modified the plan to add the following three (3) components (**see pg 18 of County plan for explanation of beginning the project without the use of innovation funds**).

These added elements will begin on July 1, 2019:

1. Participants may choose to attend weekly group visits, led by a peer support specialist or case manager, to the local healthcare district gym, with transportation provided; followed by a healthy lunch afterward
2. Participants may choose to attend group support sessions, led by a peer specialist, that will also incorporate the cooking of healthy foods
3. The provision of healthy snacks will be made available for participants when meeting for appointments with the medical provider or Nurse Health Educator

The first two elements that were added target nutrition and exercise which directly correlate to reducing the risk of metabolic syndrome. **It is unclear if the addition of nutritional and behavioral interventions assist the County in meeting innovation criteria.**

The County states the innovation is two-fold: 1) this project supports the collaboration of mental health staff located at the VAIC mental health clinic and the medical team from the County's physical health clinic, consisting of a medical provider, medical assistant, and a public health nurse to coordinate treatment of mental health consumers who may be at risk of metabolic syndrome; and 2) this project will address risks associated with metabolic syndrome holistically.

The Community Planning Process

Tulare County's local 30-day public comment period began on December 8, 2017, followed by the approval from their Mental Health Board on January 9, 2018. The County received Board of Supervisor approval on May 22, 2018.

The Community Program Planning (CPP) process for this Innovation Project meets the standards established by WIC 5848(a) in that the County states that they have included stakeholders during the development of this project. The County states stakeholder meetings, approximately 900 completed surveys, and 28 focus groups led them to the development of this project during their community planning process (**see description of CPP components beginning on pg 33 of County plan**). During the Three Year Program and Expenditure Plan CPP processes, the County reports that the completed English and Spanish surveys yielded results that untreated medical conditions received the 6th highest response and the 4th highest response, respectively. Although feedback yielded these rankings, the County chose to focus efforts on this project as they have implemented other programs to address identified needs that received higher rankings of importance. **It is unclear if consumers who receive antipsychotic medications were included as part of the CPP.**

In accordance with MHSA General Standards, the County claims this project is client and family driven and participation in this project is at the sole discretion of the participant. In support of wellness and resilience, the utilization of peers in this project will provide support for participants in their journey to wellness and the County asserts their Mental Health Cultural Competency Committee will meet on a monthly basis to discuss implementation and evaluation.

This innovation project was originally shared with MHSOAC stakeholders on December 18, 2017, during the County's public comment period. It is unknown if the County received any letters of opposition or support; however, a letter of opposition was received at the Commission via email dated July 24, 2018 from a resident of Tulare County (letter included as handout, permission to share letter granted by stakeholder)

- The letter stated that the community planning process was not inclusive of stakeholder input as the project may suggest. Rather, this project was not discussed with stakeholders until it was brought forward to the mental health board for approval. Although several innovation stakeholder meetings were held, this project was never discussed and the public was unaware of what metabolic syndrome was. It is also alleged that the explanation for this project provided to the mental health board differed than the explanation given to the board of supervisors.

This project was shared again with MHSOAC stakeholders on February 21, 2019; no letters of support or opposition were received.

Learning Objectives and Evaluation

Tulare County plans on implementing a project that will target mental health consumers at the Visalia Integrated Clinic (VAIC) who are being administered injectable antipsychotic

medication. It is estimated that approximately 120 consumers will be served over the duration of the project. As their primary purpose, the County hopes to "promote interagency collaboration related to mental health services, supports, or outcomes."

Guiding their project, the County has identified several learning goals, aimed at determining whether or not the target population receive treatment and see improvements in their modifiable health behaviors related to metabolic syndrome, increase mental health clinic staff attention to metabolic syndrome, and whether or not interagency collaboration takes place over the course of the project (**see pg. 22 of County plan**).

Measures and indicators that will be used to evaluate both the implementation of the program as well as consumer outcomes are laid out on **pages 25-29 of the County plan**. All of the measures and indicators are sufficient and clearly linked to the learnings goals of the project.

In order to gather the information necessary for evaluation, the County will collect data from several sources, including: participants' mental health and physical records, vital statistics and results from the Staying Healthy Assessment, improvement plans, participant attendance, as well as from survey instruments (**see pgs. 24, 29-30**).

Tulare County will use three different methods to evaluate their program. First, a pre-post design utilizing surveys and health record information that will help to develop a baseline and to determine whether intended participant outcomes of the project are met. Secondly, to understand providers' knowledge and attitudes toward the incorporation of metabolic syndrome, a case-control design will be utilized. All Tulare County psychiatric providers will be asked to fill out a survey related to metabolic syndrome. VAIC psychiatric providers will be provided with education and training related to metabolic syndrome. Responses form surveys will be compared between VAIC psychiatric providers who received training, and non-VAIC psychiatric providers that did not receive training. Lastly, to gain insight into interagency collaboration, the County will utilize qualitative data collection methods.

The County has presented a robust evaluation plan. As the primary purpose identified by the County is to promote interagency collaboration, qualitative methods are appropriate, however, **the County may wish to discuss what it is exactly they want to learn through this method. Specifically—what is it about the promotion of interagency collaboration from this project that the County hypothesizes will be beneficial to statewide learning?**

The County will enter into a contract with an outside evaluator to oversee the evaluation, and complete the final evaluation report. At the conclusion of their project, Tulare County will present findings to local stakeholders, the community though publication of a news article and other social media avenues. Additionally, if results are positive, the County will submit findings to a best-practice registry.

The Budget

Tulare County is seeking approval for this five (5) year project in the amount of $1,610,734. Personnel costs for this project will be $904,785 (56% of total budget) to cover the various staff needed for this project (**see pgs 50-51 of County project for list and duties of all project staff**).

The County states operating costs for this project will be $522,985 (32.5% of total budget). Direct costs will cover various medical and office supplies to cover medical testing and screening, gym access followed by healthy lunches for participants, snacks provided during appointment times, along with the cost of food to facilitate cooking lessons of healthy meals. Indirect costs will cover overhead expenses as a result of program oversight and administrative costs. Non-recurring costs total $133,714 (8.3% of total budget) for medical equipment and machines, furniture, and computer equipment for the medical exam rooms. A total of $49,250 (3.1% of total budget) is allocated for a County contractor to complete the evaluation.

In reference to Assembly Bill 114 (AB114), the County will be using funds subject to reversion for this innovation project in the amount of $692,999. In terms of sustainability, the County states they will continue this project utilizing CSS funds. **The County may wish to provide rationale as to why this project and budget is being requested as the County has been implementing this project since April 2018, utilizing Community Service and Supports (CSS) funding.**

Additional Regulatory Requirements

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

References

Khatri, M. (2017), What is Metabolic Syndrome? Retrieved from: https://www.webmd.com/heart/metabolic-syndrome/metabolic-syndrome-what-is-it#1

Goldberg, J (2018), Pros and Cons of Long-Lasting Antipsychotic Drugs. Retrieved from: https://www.webmd.com/schizophrenia/schizophrenia-long-lasting-drugs#1

McEvoy, et al. (2005), Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III, *Schizophrenia Research, 80(1), 19-32. Retrieved from: https://www.sciencedirect.com/science/article/pii/S0920996405003105*

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2019-03/tulare-county-addressing-metabolic-syndrome-pilot-project-march-28-2019

TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Timothy Durick, Psy.D. • Director • Mental Health Branch

Timothy W. Lutz, MBA
Agency Director

Mental Health Services Act (MHSA) – Innovation Project Brief

Project: Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication

Background – The Tulare County MHSA Community Planning Process took place throughout 2017. It included 28 focus groups with 198 participants and almost 900 survey responses. The community survey asked the question, "In your perspective, in Tulare County, what are the main issues resulting from untreated mental illness?" In the Spanish-language survey responses, "untreated medical conditions" was the fourth-highest-ranking issue. In the English-language responses, it was the sixth-highest-ranking issue. Other programs exist to address the higher-ranking issues.

The focus group responses also helped to guide the selection of this proposed project. Focus group participants were all asked the question, "How do you define health?" The participants often included in their collective responses an awareness that mental health and physical health go hand in hand. For example, in the focus group of homeless people with severe mental illness, "Participants defined health as mental, physical, emotional, and over all well-being." Family members of children and youth considered health to be, "the overall mental, physical, and emotional state of being." In the group of older adults, "Many nodded in agreement as one participant explained health as being physically, mentally, emotionally, nutritionally, and spiritually well." The group of Spanish-speaking caregivers of youth responded that, "… having wellness meant being healthy in all aspects of life."

From its inception to today, Tulare County community members and Tulare County Mental Health consumers, families, and friends have been involved in the project's shape, form, development, objectives, and treatment outcomes. Consumers of mental health services were included in the Community Planning Process focus groups. Information on the focus group participants' mental health treatment was not collected.

The Challenge – Individuals with serious and persistent mental illness and those who take antipsychotic medications (especially second-generation antipsychotics) are more likely to develop symptoms of metabolic syndrome. Metabolic syndrome is a cluster of risk factors that includes obesity, high blood pressure, elevated blood glucose and triglyceride levels, and a low level of high-density lipoprotein (HDL) cholesterol. Metabolic syndrome can lead to serious diseases, such as cardiovascular disease and type-2 diabetes, that can both shorten people's lives and reduce their quality of life.

There is strong evidence of a high rate of metabolic syndrome among mental health consumers in our county. A peer-reviewed, published study conducted on metabolic syndrome found that among individuals who were admitted to the psychiatric hospital in Tulare County in 2013 and 2014, only 2.4% had ever been evaluated for metabolic syndrome and just 0.16% had ever been treated for it. (Previous studies suggested that the prevalence of metabolic syndrome in this population is 40-60%). During the study's intervention, which included computerized scanning of medical records to determine whether patients met the metabolic syndrome criteria, 34.5% met them.

The Proposed Project – This project will voluntarily screen for metabolic syndrome and its components in individuals taking injectable antipsychotic medications, in an adult mental health clinic. The project will address metabolic syndrome in two main ways: (1) facilitating medical treatment by participants' primary care providers, and (2) helping participants make changes in their modifiable health behaviors that have an impact on the components of metabolic syndrome.

Main project elements include:

1. On a voluntary basis, participating consumers taking injectable antipsychotics are screened quarterly for metabolic syndrome by a licensed medical provider in a physical exam room at an adult mental health clinic.
2. For participants who screen positive or at-risk for components of metabolic syndrome, facilitate treatment by their primary care providers.
3. After every appointment, every three months, ask participants to report on their health-related activities by filling out the California Department of Health Care Services' *Staying Healthy Assessment* (available in many languages).
4. Following their licensed medical provider appointments, participants work with a Certified Nurse Educator to develop modifiable health behavior plans in domains related to metabolic syndrome: diet/nutrition, exercise, alcohol consumption, and tobacco use.
5. The Certified Nurse Educator provides helpful information and warm referral to supportive services and activities to help participants make positive changes in their modifiable health behaviors related to metabolic syndrome.
6. After every licensed medical provider appointment, the Certified Nurse Educator meets with the participants to review their progress and, as needed, modify their health behavior plans in collaboration with the participants.
7. Mental health clinic staff members receive education about metabolic syndrome.
8. Information related to this project, such as screening results and personalized health behavior improvement plans, are included in the mental health electronic records of each participant.
9. Participants' mental health treatment teams are asked to review the above information before or during their contacts with participants, to speak with them about their progress toward their health behavior plan goals, and to offer support.

We propose to <u>add three interventions</u>, starting in July 2019:

1. Voluntary weekly participant group visits to a gym with a healthy meal afterwards
2. Voluntary weekly hands-on cooking classes and health and wellness support group meetings
3. Healthy snacks available to participants before and after appointments with the licensed medical provider and Certified Nurse Educator

Implementation of the original version of this project began in April 2018, out of a need to address continuity of care and whole-person care, which are essential. In addition, the Mental Health Branch had established a strong working relationship with the Public Health Branch, and both were ready to begin the project. While the original project is innovative, these three interventions will be added, to be implemented with the start of Innovation funding. When considering new interventions for this project, we kept in mind the recommendations of the Substance Abuse and Mental Health Services Administration (SAMHSA) 2012 report "Health Promotion Programs for People with Serious Mental Illness." The study recommends: "Lifestyle health promotion programs of longer duration (3 or more months) consisting of a manualized, combined education- and activity-based approach, and incorporating both nutrition and physical exercise are likely to be the most effective in reducing weight, improving physical fitness and improving psychological symptoms and overall health." In line with these recommendations, the two major new interventions we are adding have a long duration (ongoing for the

life of the project), combine education and activities (hands-on cooking classes and gym visits), and include both nutrition and physical exercise.

Target Population – Consumers of mental health services at the Visalia Adult Integrated Clinic who take injectable antipsychotic medications and who volunteer to participate in this project. Approximately 120 consumers at the clinic currently receive treatment with injectable antipsychotics.

The Innovation – Metabolic Syndrome Project hopes to introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting, with the primary purpose of promoting interagency collaboration related to mental health services, supports, or outcomes. This project is innovative because it:

- Addresses a serious physical health condition that is more common among individuals who have a serious and persistent mental condition, and that has a common psychiatric treatment (antipsychotic medication) as a causal factor.
- Helps with this physical health condition in a mental health clinic setting, to make it easily accessible to consumers of mental health services. It is a collaboration between mental health care and physical health care organizations.
- Does so more comprehensively than other programs we have found in the literature, and in a holistic fashion.

Evaluation – Conducted by an External Evaluator. Learning objectives:

1. Can this project increase the number of individuals taking antipsychotics who are diagnosed and treated for metabolic syndrome?
2. Can this project improve participants' indicators of the components of metabolic syndrome?
3. Can this project improve participants' modifiable health behaviors related to metabolic syndrome?
4. Can this project increase the degree to which mental health clinic staff take metabolic syndrome and related modifiable health behaviors into account within mental health treatment?
5. Can strong interagency collaboration take place over the course of this project?
6. Will the two major new interventions to start in July 2019 – (a) weekly group visits to a gym with a healthy lunch afterwards and (b) a weekly hands-on cooking class and health and wellness support group – improve participant outcomes?

Outcome indicators:

1. Percentage of participants screened for metabolic syndrome quarterly.
2. Number of participants meeting the criteria for metabolic syndrome or components of metabolic syndrome, according to the licensed medical provider at the adult mental health clinic.
3. Number of participants being treated for metabolic syndrome or its components.
4. Participants' quarterly measurements of waist circumference, body mass index, blood pressure, hemoglobin A1c, total cholesterol, LDL cholesterol, HDL cholesterol, and triglyceride levels.

5. Participants' quarterly responses regarding their modifiable health behaviors on the *Staying Healthy Assessment* in domains related to metabolic syndrome: diet/nutrition, exercise, alcohol consumption, and tobacco use.
6. Number of times clinic psychiatric providers mention metabolic syndrome or components thereof – screening, diagnosis, or treatment – in their progress notes on participants, comparing the six months before the start of the project to the six months before the end.
7. Pre/post psychiatric provider survey indicators addressing confidence in diagnosing metabolic syndrome, frequency of screening, and consideration of metabolic syndrome in choosing a medication to prescribe.
8. Pre/post survey for selected mental health clinic staff members, measuring awareness of metabolic syndrome as a risk factor for cardiovascular disease.
9. Qualitative collection of instances of interagency collaboration over the course of this project.

The evaluation of Learning Objective 5 – "Can strong interagency collaboration take place over the course of this project?" – will involve the detailed qualitative collection of all instances of interagency collaboration between Tulare County's Mental Health Branch and Public Health Branch that enabled this project to start implementation and then continue to its conclusion. (We anticipate including another agency, the largest hospital district in our county, in the near future, and we will also document this collaboration.) The aim of this effort will be to provide helpful information to other California counties interested in developing integrated projects that include the provision of both mental health services and physical health services. Two of the main questions the effort will attempt to answer are: (1) "What steps were taken to develop and implement this project collaboratively?" and (2) "What challenges and barriers were encountered in this interagency collaborative effort and how were they addressed – and with what degree of success?"

Dissemination – As part of the final Innovation project report, findings and lessons learned would be shared statewide. The report will include evaluation results as well as descriptions of the project and all of its elements and work process. It will describe barriers encountered, how they were overcome, and changes made over time. It will include a focus on interagency collaboration. The Mental Health Medical Director intends to present the project at California medical conferences. If the project meets the criteria, we will also submit it to a best-practice registry.

Budget – Tulare County Mental Health has utilized a 5-year plan with the use of AB114 funds for this project. The anticipated start date is shown as July 2019, but will begin expenditure of funds as soon as possible. Total budget for all five years is anticipated at approximately $1,610,000. AB 114 funds utilized will come from fiscal year 2010/11 in an amount of approximately $693,000.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - TULARE COUNTY

Innovation (INN) Project Name:	**Connectedness 2 Community**
Total INN Funding Requested:	**$1,320,684**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	October 30, 2018
County submitted INN Project:	February 4, 2019
MHSOAC consideration of INN Project:	March 28, 2019

Project Introduction:

Tulare County Behavioral Health is coming before the Commission for the first time to propose the development of a collaborative relationship with local mental health providers and community leaders in an effort to incorporate consumer's cultural values and spiritual beliefs into an individual's treatment plan.

In the balance of this brief we address specific criteria that the Commission 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 Commission checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and

increases access to services, including, but not limited to, services provided through permanent supportive housing.

The County states this innovation project meets the primary purpose of increasing access to mental health services to underserved groups by introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

The Need

Tulare County states their community has expressed desire for the mental health practitioners in their County to be sensitive to, and incorporate, an individual's cultural beliefs and spirituality into their respective treatment plans and the County hypothesizes that consumers may avoid seeking behavioral health treatment because treatment services may not be inclusive of cultural appropriateness or sensitivity.

Over the years, the County indicates religious diversity has increased tremendously to reflect the cultural diversity in their community, although the County states a large portion of their mental health practitioners do not receive sufficient training in regards to religion and spirituality as part of their licensure. During the planning process for this project, the County states residents expressed sentiment that when people feel safe and included, the community thrives as a whole, and as a result, is more connected.

One particular population within the County, the LGBTQ community, was identified as needing to feel more included and connected to the community. The County states that their community tends to be on the religious and spiritual end of the spectrum and the LGBTQ community has difficulty feeling accepted and may benefit from mental health professionals who are sensitive to the religious and/or spiritual needs of this community.

Although the County has provided extensive research regarding the importance and inclusion of a person's cultural beliefs as part of a treatment plan, it is unclear how this has posed as a problem in their County. In providing technical assistance to the County regarding this project plan in January 2018 and December 2018, Commission staff expressed concern regarding the lack of data and the presenting need.

As a result, it can be implied that there may be a problem with access to culturally tailored services as expressed in community feedback. **The County may wish to discuss the need and how this is a problem within their County including relevant data to support that this project will alleviate that need.**

The Response

Tulare County proposes to have spiritual leaders in the County and mental health providers to educate each other, via training modules and surveys, on the importance of incorporating cultural values and beliefs into an individual's treatment plan. The County feels this will create a meaningful partnership in the community, resulting in an increase in consumer participation of behavioral health services along with the incorporation of cultural values and beliefs as part of the treatment plan.

The County indicates their first step will be to establish a definition in how cultural values and beliefs affect connectedness to a person's community. According to the StrengthsFinder theme of Connectedness, a person who has connectedness is able to "build a bridge of understanding" and are able to create more meaningful interactions with people (Schubring, 2014). As stated previously, the community has expressed to the County that they feel connected to their community when they feel safe and included and the community thrives as a result. **The County may wish to discuss or provide rationale as to the problem within their community resulting in non-connectedness.**

For this project, the County will work with a contractor to develop training modules for licensed providers. The contractor will identify and recruit subject matter experts with various cultural, spiritual, and religious backgrounds who will then collaborate in the development of the training modules. The overarching goal of this project is to have providers incorporate a person's beliefs and values into their treatment plan while the cultural leaders become more aware of mental health and illness/wellness. The County has identified three (3) subject matter experts to conduct training in year one:

1. Tule River Rancheria with focus on the Native American population
2. The Source will focus on the LGTB population
3. New Life will focus on the African American population

The County states they will focus on Asian and Pacific Islanders as well as the Monolingual Spanish speaking populations. **The County may wish to provide rationale as to why training modules for the Spanish speaking populations will not be developed until the second year of the project, given the County's large Spanish speaking population.** The Commission has previously approved other innovation projects focused on the incorporation of cultural traditions. Orange County's innovation project, Religious Leaders Behavioral Health Training, approved on April 24, 2014, utilized the train-the-trainer technique. A behavioral health training program was created in order to train religious leaders from 30 faith-based organizations who would then continue providing training to other religious leaders on the importance of behavioral health interventions. Santa Clara's innovation project, Faith Based Training and Supports Project, approved on November 16, 2017, proposed the development of a dual training program for faith/spiritual leaders and behavioral health specialists. Behavioral health specialists would educate spiritual leaders so that they could effectively assist their parishioners more, and refer to behavioral health services, as needed. Spiritual / faith leaders would then educate behavioral health specialists on the importance of religion and spirituality as part of the treatment plan.

The County states this project differs from the previously approved projects because they will focus on traditions and practices beyond the religious aspect. Additionally, the County hopes to include the LGBTQ community to address their specific needs, cultural beliefs, and values. **The County may wish to explain what they mean by stating this project will focus on "traditions and practices beyond the religious aspect".**

In working with the County on this project, concern was expressed by Commission staff via technical/consultative calls along with emails regarding the unclear need and baseline data to support the need for this project. Current concerns remain

unanswered as expressed when plan was originally brought forward to Commission staff in December 2017.

The Community Planning Process

Tulare County's local 30-day public comment period began on December 8, 2017, followed by the approval from their Mental Health Board on January 9, 2018. The County received Board of Supervisor approval on October 30, 2018.

The County states their community planning process consisted of a robust stakeholder team which contributed feedback for this project in the form of stakeholder meetings, 28 focus groups, and 884 responses from surveys in addition to the public hearing (**see pgs 12-13 of County plan for complete list of community stakeholders**).

The Community Program Planning (CPP) process for this Innovation Project meets the standards established by WIC 5848(a) in that the County states that they have included stakeholders during the development of this project. During the Three Year Program and Expenditure Plan CPP processes, the County reports that it heard repeated requests from their community for providers to be more sensitive to a person's religious, spiritual, and cultural beliefs and values. The County states that not all 884 survey responses indicated the need for providers to be more culturally aware and sensitive; however, the data collected and analyzed revealed themes regarding the need for more cultural awareness and competence for specific unserved and underserved cultural communities such as Native American, South East Asian, African American, and Monolingual Spanish.

This innovation project was originally shared with MHSOAC stakeholders on December 18, 2017, during the County's public comment period. It is unknown if the County received letters of opposition or support; however, no letters of opposition or support were received at the Commission at that time. This innovation project was shared again with MHSOAC stakeholders on February 21, 2019; no letters of support or opposition were received.

Learning Objectives and Evaluation

Tulare County plans on implementing a project that will target clinicians, as well as consumers, and their family members. It is estimated that approximately 200 consumers and professional clinicians will be served per year. As their primary purpose, the County hopes to "Increase access to mental health services to underserved groups."

Guiding their project, the County has identified three learning goals, and seek to (1) educate and train community therapists on addressing connectedness to community, (2) increase access to services through appropriate training and linkage, and (3) to create a protocol for incorporating cultural values, practices, and beliefs into mental health therapeutic strategies.

The County has included **measures** that will be utilized as part of their logic model on **page 30 of their plan,** and include: number of staff trained, number of community members engaged, number of training sessions conducted, number of clients served, among others. Additionally, the County plans on measuring adherence to a treatment

plan, demonstrated competencies of trained therapists, reflections of new populations served, perception of care, and status at reassessment. **While some of the measurements for outcomes have been identified, more specifics are needed—for example, how will demonstrated competency, and increases in connectedness be measured? Additionally, considering a lack of baseline data around the need and penetration rates, the County may wish to further discuss how an increase in access to services will be tracked and measured relative to the implementation of the culturally tailored strategies that are developed.**

In order to gather the information necessary for evaluation, the County will collect data from intake assessment tools, culturally tailored engagement strategies, and through surveys and interviews with subject matter experts, therapists, and consumers. The County will use a pre-post design utilizing data collected from surveys and intake assessment tools to develop a baseline and to determine whether outcomes are met as a result of the implementation of culturally tailored strategies. Further inquiry will also be made through the use of qualitative methods to better understand consumer response.

While the overall evaluation plan appears sufficient to evaluate the primary purpose of increasing access to mental health services, further development is needed. The County will enter into a contract with an outside evaluator to oversee the evaluation, and complete the final evaluation report. **The County may wish to describe how findings and lessons learned from their project will be disseminated and used to contribute to statewide learning.**

The Budget

Tulare County is seeking approval for this five (5) year project in the amount of $1,320,684. Personnel costs for this project will be $423,084 (32% of total budget) for the Administrative Specialist position who will oversee the development of this project (**see pg. 20 of County plan for detailed duties of this position**).

The County states operating costs will be $140,219 (10.6% of total budget). Direct costs will cover resource materials such as handouts, booklets, and pamphlets while indirect costs will cover conference room reservation costs and speaker fees for meetings and trainings.

Technology costs in the amount of $6,000 (0.5%) will cover the purchase of a laptop, projector and screen, along with Jabber licensing fees which will be used to facilitate trainings for providers to participate online.

The largest portion of this project is allocated for contractor costs in the amount of $727,881 (55% of total budget). Contractor costs will cover the program consultant, evaluator, and the subject matter experts that will be utilized for this project. **County may wish to discuss the expected deliverables to be received regarding budget associated with contractor costs.** The County is anticipating a total of $23,500 (1.8%) to cover costs associated with the printing of materials, meeting and training venue fees, cell phones for administrative staff, travel reimbursement, and supplies for the trainings along with office supplies.

In reference to Assembly Bill 114 (AB114), the County will be using funds subject to reversion for this innovation project in the amount of $494,322. In terms of sustainability, the County states they may continue this project utilizing Community Services and Supports (CSS) funds.

Additional Regulatory Requirements

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

References

Schubring, L (2014), How to Understand the StrengthsFinder Theme of Connectedness. Retrieved from: https://www.leadershipvisionconsulting.com/how-to-understand-the-strengthsfinder-theme-of-connectedness

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2019-03/tulare-county-connectedness-2-community-march-28-2019

TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Timothy Durick, Psy.D. • Director • Mental Health Branch

Timothy W. Lutz, MBA
Agency Director

Mental Health Services Act (MHSA) – Innovation Project Brief

Project: Connectedness 2 Community

Background – Throughout 2017, the Tulare County MHSA Community Planning Process took place, involving 28 focus groups with 198 participants, and almost 900 survey responses. The top 3 barriers to accessing mental health services were lack of transportation and appointment availability, which are being addressed in other efforts, and finding a mental health professional with whom consumers and family members were comfortable. Upon further exploration of this theme during focus groups, consumers expressed they want to feel their cultural/group beliefs and practices, to include their interests, attitudes and outlook on life, are being respected and intentionally included in their treatment plans.

The prevalent community need, ranked at #4 in our community survey, was access to mental health providers who have discernment and cultural awareness. Competent care through the foundation of basic knowledge about values and beliefs, understanding of how they are interwoven into human behavior, and the skills to assess and address cultural values and beliefs will require a new approach from the traditional training of mental health practitioners. Homelessness, substance abuse, and suicide were the top three community needs identified through the CPP, and Tulare County Mental Health has several efforts working to address these needs. The Suicide Prevention Task Force and Alcohol and Other Drug Unit continue to improve and expand existing programs. To address homelessness, the Mental Health Branch works in partnership with the Homeless Task Force which was created in late 2017, in addition to pursuing such grant funding opportunities as No Place Like Home and the Homeless Mentally Ill Outreach and Treatment Program.

The Challenge – While the health care system is constantly changing and expanding to better address the growing issues with mental health, we can definitely improve how mental health issues are perceived and how they are treated among different cultures and ethnic groups. It is clear that different cultures view mental health differently, see different causes for the issues and look to different areas for help.

During Tulare County focus group discussions, consumers expressed that while providers spoke the same language, they "did not understand the culture and the spirituality of the cultural group". Many discussion participants expressed feeling misunderstood and, as a result, do not continue to seek appropriate treatment. Cultural sensitivity on the part of the therapist may be beneficial to treatment because it may lead to a broader evaluation of the person seeking treatment and allow the therapist to explore a wider variety of treatment solutions. (Spirituality As a Coping Mechanism, www.goodtherapy.org Feb. 2017)

The term "cultural awareness" needed to be defined and, through discussion with focus groups and stakeholders, the term was defined to be broader than merely ethnicity. Cultural considerations include, but are not limited to: ethnicity, race, age, gender identity, primary language, English proficiency, sexual orientation, immigration status, acculturation factors, sacred beliefs and practices, physical abilities and limitations, family roles, community networks, limited literacy, employment, and/or socioeconomic factors.

Tulare County also looked at data for those we serve over the last three fiscal years. To address the focus groups' concern about people not coming back for services, staff looked at those who received one service only during this time period, eliminating those whose one service resulted in not qualifying for services at these clinics. There were 107 African-American individuals who came to the clinics seeking services, and 11 of them did not return, approximately 10%. For the Native American population, there were 37 who came in, and 5 did not return, approximately 13.5%. The Hispanic population had 1,969 individuals who came in for one service, and 195 who did not return, also 10%.

Focus groups and stakeholders also noted that the LGBT+ population is not tracked, and stated that many LGBT people here in Tulare County simply do not seek services in the first place due to the stigma and knowing that they are not represented. (Sexual orientation and gender identity are demographic data tracked by programs funded by PEI and INN MHSA funds. This data comes from the clinics, which are not funded by PEI or INN.)

The Proposed Project – Connectedness 2 Community proposes to bridge the gap in understanding through education and coaching, connecting with community leaders and cultural brokers. The community and faith-based leaders, as well as cultural brokers, will assist in expanding providers' awareness of an individual's cultural values and beliefs, and these same leaders will become better informed about mental health diagnoses, wellness and recovery. This will result in reducing the stigma and discrimination across the community. This program will include development and implementation of coaching modules from both sides of the partnership, as well as round table discussions and operating supports for targeted community organization leadership to sustain the work.

For the first year of this five-year project, Tulare County Mental Health will partner with three community populations: The Source for the LGBT+ focus, Tule River Rancheria for the Native American focus, and New Life Ministry for the African American focus. These partners were chosen during stakeholder meetings. For the second year of the project, the Asian/Pacific Islander and Monolingual Spanish speaking populations will be the focus. The stakeholders felt more study was needed in reaching out to these populations and building relationships. Within each of these two groups, there are many subgroups, thus the stakeholders chose to build in time to discover the relevant subgroups for Tulare County.

Target Population – The project will target community leaders and cultural brokers, clinical providers, and consumers. The first focus will be to community leaders and cultural brokers, contracting with them to participate and lead round-table discussions about the specific and unique needs of their communities, and building trust. Next, the focus will be to clinical providers, utilizing the connections to the community leaders to broaden the base of understanding and lead to new ways of thinking about treatment modalities. Both groups will participate in pre/post surveys to assess knowledge, understanding, and learning. The third target group will be consumers, measuring an increase in these population groups seeking services, and staying engaged in services. It is estimated that this program will reach approximately 200 consumers and professional clinicians per year.

The Innovation – Connectedness 2 Community aims to introduce a new mental health practice or approach, with the primary purpose of increasing access to mental health services for underserved groups. When examining literature related to incorporation of cultural values, beliefs and practices with a resulting community connectedness within mental health treatment, D. Cornah (2006) found that, for many, clinicians did not consider an individual's cultural values and beliefs. Research has shown more positive outcomes occur when mental health providers ask consumers about their cultural values and beliefs upon entry to the program and throughout their care and treatment. With the provider initiating the conversation, they can assist the consumer with identifying those aspects of life that provide them with meaning, hope, connectedness and purpose. For example, in the monolingual Spanish-speaking and Native American cultures, if providers were culturally informed and open to combining cultural beliefs and modern mental health practices, there would be an increase in consumers receiving effective services. (Maldonado, 2015)

Other counties have brought forward and received approval for projects with community leaders, specifically faith leaders (Orange County's "Religious Leaders Behavioral Health Training", and Santa Clara's "Faith Based Training and Supports Project").

This project differs in that it expands beyond religion to include cultural traditions, practices, etc. For example, this project might enlighten providers about how Native American or Asian/Pacific Islander elders are valued and how those elders influence the community's way of thinking, or how LGBT support is identified when a person is asked "what pronoun do you prefer?" This project goes beyond looking at the religious aspect, although it does include it as well, in working with New Life Ministries for the African American focus.

Evaluation – The oversight of this project will be conducted through the Mental Health Cultural Competency Committee. Many of the stakeholders, consumers, family members, within this group were instrumental in the development of this project. This would also be the primary venue for vetting next steps and decisions related to continuation of the project at the end of the five years.

Learning Objective #1: To educate and train the community therapists on the sensitivity of addressing connectedness to community via the cultural/group lens through leveraging the engagement of cultural brokers/leaders in curriculum development and training delivery;

Learning Objective #2: Increase access to services by providing coaching and support to cultural brokers/leaders on County behavioral health basics, which will help them respond appropriately to individuals seeking their help and assist with linkage and referrals to county behavioral health services; and

Learning Objective #3: To create an established protocol incorporating different cultural values, practices and beliefs as part of mental health therapeutic strategies.

Measures and performance indicators would be based upon data such as adherence to treatment plan, demonstrated new competencies of trained therapists, reflection of new populations served, perception of care, and status at reassessment of targeted clients. Additionally, qualitative data will be collected int the form of the stories that emerge from the connectedness work through the diverse partnerships established through this initiative.

Information can be obtained through the use of surveys, given before and after each training session with Subject Matter Experts. Consumers and participants will be asked to complete surveys on the services they receive pre and post treatment. Interviews also will be held with therapists, at least six months after initial training is completed. Most data will be collected at the time of encounter. Some instruments may be administered digitally (Survey Monkey, etc.).

At the end of the 5-year project, Tulare County Mental Health anticipates development of coaching and informational modules for the population groups highlighted, in addition to having developed additional training modalities. As part of the final Innovation project report, these as well as findings and lessons learned would be shared statewide.

Budget – Tulare County Mental Health has utilized a 5-year plan with the use of AB114 funds for this project. The anticipated start date is shown as July 2019, but will begin expenditure of funds as soon as possible. Total budget for all five years is anticipated at approximately $1,320,000. AB 114 funds utilized will come from fiscal year 2010/11 in an amount of approximately $495,000.

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AGENDA ITEM 5

Action

March 28, 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 positon on the following bills:
Senate Bill 582 (Beall) and Senate Bill 604 (Bates).

- **Senate Bill 582 (Beall):** Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients. Senate Bill 582 is identical to Senate Bill 1019 that the Commission Sponsored in February 2018 and was passed by the Legislature in August 2018. The Governor Vetoed Senate Bill 1019 leaving the allocation decisions with the Commission.

- **Senate Bill 604 (Bates):** Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish centers of excellence to provide the counties with technical assistance to implement best practices related to elements of the Mental Health Services Act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act.

Presenters:
- Sarah Couch, Legislative Director, Office of Senator Bates
- Toby Ewing, Executive Director, MHSOAC

Enclosures (4): (1) SB 582 (Beall) Fact Sheet; (2) SB 582 (Beall) Bill Text; (3) SB 604 (Bates) Fact Sheet; (4) SB 604 (Bates) Bill Text.

Handout: None

SENATOR JIM BEALL
SB 582: School-Based Mental Health Partnerships

SUMMARY

SB 582 creates parity and access to school-based mental health services by accomplishing the following:

- Restores the unprecedented 40% cut to mental health triage grants under Governor Brown's 2018 budget, improving early intervention of mental illness.
- Allocates at least half of the triage grant funding for services targeted to youth and encourages partnerships between schools and local mental health services.
- Requires these grants to be administered by the Mental Health Services Oversight and Accountability Commission (Commission) in consultation with the California Department of Education effective July 1, 2021.
- Specifies that allowable uses of the funding be broadened to support prevention, early intervention, and direct services to address health needs of youth.
- Establishes eligibility standards for grants to include a local education agency and a county and/or a qualified mental health provider operating as part of the county mental health plan network.

BACKGROUND

The Mental Health Services Accountability and Oversight Commission (Commission) found that children are more likely to experience or express a mental health crisis in a school setting and thus school-based programs can effectively respond and support the shared goals of promoting mental health and achieving desired educational outcomes for youth with mental health needs.

According to the Centers for Disease Control and Prevention, up to 20 percent of Americans under the age of 18 suffer from mental, behavioral, or emotional disorders.[1] This translates to approximately 15 million children across the country, according to the latest U.S. Census figures. Children with mental health problems are vastly more likely to develop substance abuse problems, become involved in criminal activity, and drop out of school. Among Americans ages 10 to 24, suicide is the third-leading cause of death.[2]

Partnerships between schools and community mental/behavioral health professionals offer students and families an extended network of mental health programs and services that are easily accessible. When programs are able to identify and address student mental and behavioral challenges early, students are more likely to gain resiliency skills and be successful in school and life while the threat of later harm is reduced.[3] Although youth mental health outreach has demonstrable benefits to children, only a handful of California schools have partnered with county mental health agencies and existing Triage funds are primarily utilized for adult mental health services.

According to the Commission, in the first round of the Triage grants in 2018, 50 applications for program funds were received. Only 6 of these proposed programs were specific to youth, and only 3 of those met or exceeded the minimum threshold for funding. Therefore, the grantees with youth-centric programs received just over 15% of the total available Triage funds. In order for California's school-age population to be adequately served, parity in the Triage grant fund allocation is a necessary first step.

EXISTING LAW

Existing law established the Investment in Mental Health Wellness Act of 2013 (SB 82) and provided that funds appropriated by the Legislature to Commission be used to provide a complete continuum of crisis services for children and youth.

Following the enactment of SB 82 in 2014, the Legislature followed up with the passage of SB 833 and modified the statute to clarify that Triage funds can and should be used to support crisis services for children and youth. SB 833 also directed the Commission to develop a program specific to meeting the needs of children, and provided $1.5 million for the purpose. The Legislation provided an additional $1.5 million to expand family supportive

[1] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Vol. 62, No.2, May 17, 2013

[2] NAMI, Mental Health Facts Children and Teens Infographic

[3] Psychiatric Services 66:9, September 2015

training and related services designed to help families participate in the planning process, access services, and navigate programs (W&C 5848.5(h)). In response to the legislation, as well as the likelihood that counties would again seek to dedicate the vast majority of Triage funds to programs serving adults, the Commission elected to require half of Triage funds to be dedicated to programs targeting children and youth. Within that dedication, the Commission also directed $30 million of those funds to be set aside specifically for crisis Triage programs that can be developed through an integrated county mental health – school partnership.

In Governor Brown's 2018 budget, Triage funds were unexpectedly cut by 40 percent, or approximately $15 million per year. The Commission responded by shifting from a 3-year funding cycle to a 4-year cycle and drastically limiting grant totals. This bill seeks to reverse this cut, and normalize grant cycles administered by the Commission.

FOR MORE INFORMATION

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SENATE BILL No. 582

Introduced by Senator Beall

February 22, 2019

An act to amend Section 5848.5 of the Welfare and Institutions Code, relating to youth mental health, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 582, as introduced, Beall. Youth mental health and substance use disorder services.

Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the act be made available through a grant program to selected counties or counties acting jointly, except as otherwise provided, and be used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

This bill would require the commission, when making grant funds available on and after July 1, 2021, to allocate at least ½ of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients. The bill would require the commission to provide a status report to the fiscal and policy committees of the Legislature, as specified, no later than March 1, 2022. The bill would additionally annually appropriate $15,000,000 each fiscal year

to the commission for the purpose of grants by the commission pursuant to these provisions.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Schools are the best place for early identification and alleviation of behavioral health challenges that are likely to lead to serious mental illness or substance use disorders if not addressed early in their onset.

(b) School-based healthcare programs substantially increase children's access to care, even for children covered by Medicaid or private health insurance. Prior research studies have linked school-based healthcare and mental health services to better child behavior in school, reduced emergency department usage by children, higher rates of educational success, and lower rates of teen births. While it is unclear which specific school-based health programs are most cost effective, the benefits of having at least some type of healthcare at every public school are typically far greater than the costs.

(c) California ranks at or near the bottom of all states in terms of the percentage of K-12 public students with access to various types of healthcare or mental healthcare inside their schools. California ranks 39th for school nurses per student, and 50th for school counselors per student. California ranks 43rd for Medicaid spending per student on school-based health and mental health services. Yet California's youth do not have low needs; for example, California ranks 28th among states in terms of the estimated percent of children with a serious emotional disturbance.

(d) Less than one-half of California's public school students have regular access to physical healthcare in their schools, less than one-half of California's elementary school students have access to mental healthcare in their schools, and more than 5 percent of California's high school seniors do not have access to a school counselor.

(e) Gaps in school-based health coverage are present throughout the state. Only 16 percent of school districts provide mental health

coverage for all elementary school students. More than one quarter of school districts have at least one high school not offering any counselors. School-based healthcare coverage for the general student population is especially low in rural areas and in schools with high rates of special education classifications.

(f) Nonprofit organizations and other government agencies, such as local health districts, county departments of health, and local police departments, help to increase student access to school-based healthcare and especially mental healthcare, but these efforts are sporadic.

(g) Multitiered models to improve school climate and culture and to ensure prompt referral for support for students showing any level of challenge, and comprehensive integrated services for those with serious emotional disturbances or substance use disorders have been demonstrated to have the best outcomes in improving student health and academic performance.

(h) These integrated models, when able to leverage public or private health insurance funds, demonstrate that early investments pay for themselves in reduced special education costs and improved academic success while reducing school dropout rates and related problems.

(i) Initially, approximately 85 percent of triage grant funds are allocated to adult mental health services, leaving youth underserved. According to the Mental Health Services Oversight and Accountability Commission, in the first round of triage grants, only 6 of 50 applications for program funds received were specific to youth, and only three of those met or exceeded the minimum threshold for funding.

(j) Grantees with youth-centric programs received just over 15 percent of the total available triage funds. In order for California's schoolage population to be adequately served, parity in the distribution of triage grant funds is necessary.

(k) By allocating funds for the purpose of establishing partnerships between schools and local mental health plans, the entities involved would be able to leverage school and community resources in order to provide comprehensive multitiered interventions on a sustainable basis, which can yield greater mental health outcomes for California's youth.

SEC. 2. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective outpatient and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental ~~health care~~ *healthcare* needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental ~~health care~~ *healthcare* disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the ~~2016~~ Budget Act *of 2016* for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental ~~health care~~ *healthcare* needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental ~~health care~~ *healthcare* disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as ~~health care~~ *healthcare* providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental ~~health care~~, *healthcare*, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis

stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of ~~implementation,~~ *implementation* that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority and the commission to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this

designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as ~~health care~~ *healthcare* providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental ~~health care,~~ *healthcare,* linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the ~~California~~ *County* Behavioral Health Directors ~~Association.~~ *Association of California.*

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program

expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of ~~implementation,~~ *implementation* that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating the local service sector to improve efficiencies and the delivery of services.

(1) Triage personnel may provide targeted case management services face to face, by telephone, or by telehealth with the individual in need of assistance or ~~his or her~~ *the individual's* significant support person, and may be provided anywhere in the

community. These service activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for triage personnel as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel and use of peer support.

(C) Description of how triage personnel will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or city mental health department that receives an award of funds for the purpose of supporting triage personnel pursuant to this subdivision is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2014.

(h) Funds appropriated by the Legislature to the commission ~~pursuant to~~ *as described in* paragraph (8) of subdivision (b) for the purposes of addressing children's crisis services shall be allocated to support triage personnel and family supportive training and related services. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. The commission may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) These funds may provide for a range of crisis-related services for a child in need of assistance, or ~~his or her~~ *the child's* parent, guardian, or caregiver. These service activities may include, but are not limited to, the following:

(A) Intensive coordination of care and services.

(B) Communication, coordination, and referral.

(C) Monitoring service delivery to the child or youth.

(D) Monitoring the child's progress.

(E) Providing placement service assistance and service plan development.

(F) Crisis or safety planning.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for these funds, as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel.

(C) Description of how personnel and other services will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to provide a matching contribution of local funds.

(F) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(G) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or a city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or a city mental health department that receives an award of funds for the purpose of this section is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission may waive requirements in this section for counties with a population of 100,000 or less, if the commission determines it is in the best interest of the state and meets the intent of the law.

(8) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than January 10, 2018, and annually thereafter.

(i) (1) On and after July 1, 2021, when making grant funds appropriated by the Legislature available pursuant to this section, the commission shall allocate at least one-half of the funds to local educational agency and mental health partnerships, as described in paragraph (2), through a competitive process.

(2) The commission, in consultation with the Superintendent of Public Instruction, shall establish criteria for the allocation of funds pursuant to this subdivision. In order to be eligible to receive funding, a partnership shall include one or more local educational agencies and one or more mental health partners. A mental health partner shall be either a county, including a county mental health plan, or a qualified mental health provider operating as part of the county mental health plan network.

(3) Funding allocated pursuant to this subdivision shall be available to support prevention, early intervention, and direct services, including, but not limited to, support for personnel, training, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(4) These strategies may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(5) Funding allocated pursuant to this subdivision shall be made available to meet the mental health needs of children and youth, including those with an individual education plan, pursuant to the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), or a plan adopted pursuant to Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794), as well as other children and youth in need of mental health services.

(6) In determining grant recipients, the commission, in consultation with the Superintendent of Public Instruction, shall give positive consideration to each of the following:

(A) Description of need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) Description of the funding request, including personnel and use of peer support.

(C) Description of how the funds will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnosis, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(E) Ability of the LEA to collect information on the health insurance carrier for each child or youth, with the permission of the parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(F) Ability to engage a health care service plan or a health insurer in the LEA and mental health partnership, when applicable, and to the extent mutually agreed to by the LEA and the plan or insurer.

(G) Ability to administer an effective service program and the degree to which mental health providers and local educational agencies will support and collaborate to support the goals of the effort.

(H) Geographic areas or regions of the state to be eligible for funding, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(7) The commission, in consultation with the Superintendent of Public Instruction, shall determine maximum funding awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (6).

(8) Funds awarded by the commission for purposes of this subdivision may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, city mental health departments, qualified mental health agencies, or local education agencies that receive funding.

(9) For the purposes of this subdivision, "local educational agency" or "LEA" means a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area.

(10) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means of informational letters, bulletins, or similar instructions.

(11) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2022.

(12) Nothing in this subdivision shall require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this part.

(j) Notwithstanding Section 13340 of the Government Code, the sum of 15 million dollars ($15,000,000) is hereby appropriated annually each fiscal year from the General Fund to the Mental Health Services Oversight and Accountability Commission for the purpose of allocation pursuant to this section.

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SB 604: Mental Health Services Act: Centers of Excellence

Senator Patricia C. Bates

IN BRIEF

SB 604 requires, on or before January 2, 2021, the Mental Health Services Oversight and Accountability Commission (MHSOAC) to establish centers of excellence to provide counties with technical assistance and to implement best practices.

BACKGROUND

In 2004, California voters approved Proposition 63 and the Mental Health Services Act (MHSA) was enacted in 2005 by placing a one percent tax on incomes above $1 million. It provided the first opportunity in many years to expand county mental health programs for all populations: children, transition-age youth, adults, older adults, families, and, most especially, the un- and under-served. It was also designed to provide a wide range of prevention, early intervention, and treatment services, including the necessary infrastructure, technology, and enhancement of the mental health workforce to support it.[1]

The MHSOAC has been proactive in working to provide more assistance to counties and stakeholders through a three-prong effort. The MHSOAC has made great strides in creating a roadmap to streamline project applications and support criminal justice diversion. However, locals have asked MHSOAC to improve access to information on how counties are currently delivering services, model approaches to service delivery, and access to technical assistance to improve the delivery of care.

On February 28, 2019, the MHSOAC approved a request for staff to work with the Department of Finance and the Legislature to develop a proposal to establish an Information Clearinghouse and Technical Assistance Strategy.

EXISTING LAW

Enacted by voters as Proposition 63 in the November 2004 statewide general election, the Mental Health Services Fund is a continuously appropriated fund that supports various county mental health programs. These funds can only be used for specific purposes, but can be amended by a 2/3rds vote of each house if the amendment furthers the intent of the act.

THE SOLUTION

SB 604 will require the MHSOAC to establish centers of excellence to provide counties with technical assistance to implement best practices for MHSA-related programs, including, but not limited to, full service partnerships, criminal diversion, and school-based mental health. The bill does not dictate the specific number of centers. Instead, it leaves that decision to the MHSOAC. The centers shall be funded with MHSA state administrative funds.

By providing centers that can more directly connect with counties, California will be improving the effectiveness of county MHSA funded programs.

FOR MORE INFORMATION

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Bill text and status can be found at:
www.leginfo.ca.gov

[1] http://www.mhsoac.ca.gov/history

SENATE BILL No. 604

Introduced by Senator Bates

February 22, 2019

An act to amend Section 5892 of, and to add Section 5848.3 to, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 604, as introduced, Bates. Mental Health Services Act: centers of excellence.

Existing law contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund, a continuously appropriated fund, to fund various county mental health programs. Moneys in the fund may only be used for specified purposes, including 5% for certain state administrative costs, which funds are subject to appropriation in the annual Budget Act. The act provides that it may be amended by the Legislature by a ⅔ vote of each house so long as the amendment is consistent with and furthers the intent of the act, and authorizes the Legislature to amend the act to clarify procedures and terms of the act by majority vote.

This bill would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish centers of excellence to provide the counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act.

This bill would declare that this amendment is consistent with and furthers the purposes of the act, thereby requiring a ⅔ vote.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 5848.3 is added to the Welfare and Institutions Code, to read:

5848.3. On or before January 1, 2021, the Mental Health Services Oversight and Accountability Commission shall establish an indeterminate number of centers of excellence to provide the counties with technical assistance to implement best practices related to elements of the act, including, but not limited to, full service partnerships, criminal diversion, and school-based mental health. The centers of excellence shall be funded with state administrative funds pursuant to subdivision (d) of Section 5892.

SEC. 2. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1 (commencing with Section 5820).

(2) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent for capital facilities and technological needs shall be distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional

services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850), shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) (1) In any fiscal year after the 2007–08 fiscal year, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate an amount it establishes as the prudent reserve for its Local Mental Health Services Fund, not to exceed 33 percent of the average community services and support revenue received for the fund in the preceding five years. The county shall reassess the maximum amount of this reserve every five years and certify the reassessment as part of the three-year program and expenditure plan required pursuant to Section 5847.

(c) 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 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to

Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, 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 the programs set forth in this ~~section.~~ *section and Section 5848.3.* These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(e) In the 2004–05 fiscal year, funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820).

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings

on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(i) If there are revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may

appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

SEC. 3. The Legislature finds and declares that this act is consistent with and furthers the purposes of the Mental Health Services Act within the meaning of Section 18 of that act.

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Back to Agenda

AGENDA ITEM 6

Information

March 28, 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 (6): (1) Motions Summary from the February 28, 2019 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) Presentation Guidelines; (5) Department of Health Care Services Revenue and Expenditure Reports Status Update (6) Legislative Report to the Commission.

Handouts (2): (1) Calendar of Tentative Agenda Items; (2) Legislative Tracking Report.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
February 28, 2019

Motion #: 1

Date: February 28, 2019 **Time:** 9:51 AM

Motion:

The Commission approves the January 24, 2019 meeting minutes as amended.

Commissioner making motion: Commissioner Brown
Commissioner seconding motion: Commissioner Gordon

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

Motion #: 2

Date: February 28, 2019 **Time:** 11:04 AM

Motion:

- The Commission revises the January 2019 outline for the Immigrant and Refugees stakeholder contracts to: increase the number of local program contracts from four to five, one for each of the California regions; eliminate the statewide program contract; and distribute the total funding equally to each of the five local program contracts.
- The Commission directs the Executive Director to make the necessary changes to the RFP that was released on February 15, 2019.

Commissioner making motion: Commissioner Boyd

Commissioner seconding motion: Commissioner Bunch

Motion carried 9 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 3

Date: February 28, 2019 **Time:** 12:25 PM

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

Name: Homeless Outreach and Medical Engagement (HOME) Team
Amount: $2,395,892.02
Project Length: Five (5) Years

Commissioner making motion:
Commissioner seconding motion:

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

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

Motion #: 4

Date: February 28, 2019 **Time:** 3:12 PM

Motion:

Motion: The MHSOAC approves Imperial County's Innovation plan as follows:

Name: *Positive Engagement Team (PET)*
Amount: $3,120,109
Project Length: Five (5) Years

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

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

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

Motion #: 5

Date: February 28, 2019 **Time:** 3:14 PM

Motion:

Motion: The MHSOAC approves Imperial County's Innovation plan as follows:

Name: *Positive Engagement Team (PET)*
Amount: County to work with MHSOAC staff to determine the amount of funding
Project Length: Three (3) Years

Commissioner making motion: Commissioner Alvarez
Commissioner seconding motion: Chair Tamplen

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

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

Motion #: 6

Date: February 28, 2019 **Time:** 4:26 PM

Motion: The Commission approves San Bernardino County's Innovation Project, as follows:

Name: Innovative Remote Onsite Assistance Delivery (InnROADS)
Amount: $17,024,309
Project Length: Five (5) Years

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

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

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

Motion #: 7

Date: February 28, 2019 **Time:** 4:41 PM

Motion: *The MHSOAC directs staff to work with the Administration and the Legislature to merge the $25 million General Fund for early psychosis proposed in the Governor's 2019-2020 budget with the Commission's AB 1315, Early Psychosis Intervention Plus Program.*

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Gordon

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

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

Motion #: 8

Date: February 28, 2019 **Time:** 4:42 PM

Motion: *The MHSOAC directs staff to work with the Administration and the Legislature to try to secure funding for technical assistance for the counties and the different aspects of mental health services to better track what is happening around the state so collective learning can happen.*

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Berrick

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

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

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Dashboard March 2019
(Updated March 11th, 2019)

Summary of Updates

Contracts
No Changes

Total Contracts: 4

Funds Spent Since the February Commission Meeting

17MHSOAC024	$14,775
17MHSOAC081	$0
17MHSOAC085	$0
18MHSOAC020	$0
Total	**$14,775**

Contracts with Deliverable Changes

17MHSOAC81

17MHSOAC85

MHSOAC Evaluation Dashboard March 2019
(Updated March 11th, 2019)

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	$338,873

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	No

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MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

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	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In Progress	3/30/20	No
Summary Report (3 Public Engagements)	In Progress	3/30/19	Yes
Summary Report (3 Public Engagements)	Not Started	6/30/19	No

MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

Outcomes Reporting Draft Report —3 Sections	Not Started	9/31/19	No
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

MHSOAC Mental Health Services Oversight & Accountability Commission

MHSOAC Evaluation Dashboard March 2019
(Updated March 11th, 2019)

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

MHSOAC Staff	Rachel Heffley
Active Dates	07/01/18 - 12/31/19
Total Contract Amount	$234,279
Total Spent	$50,200

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
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	In Progress	05/06/19	Yes
FSP Formatted Data Sets	Not Started	09/07/19	No
FSP Draft Report	Not Started	10/07/19	No
FSP Final Report	Not Started	12/09/19	No

MHSOAC Evaluation Dashboard March 2019
(Updated March 11th, 2019)

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

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Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD - MARCH 2019
(Current)

	NUMBER OF PLANS	COUNTIES	FUNDS REQUESTED
CALENDARED*	5	4	$6,066,353
DRAFT PROPOSALS RECEIVED	5	4	$9,240,794
TOTAL	**10**	**8**	**$15,307,147**

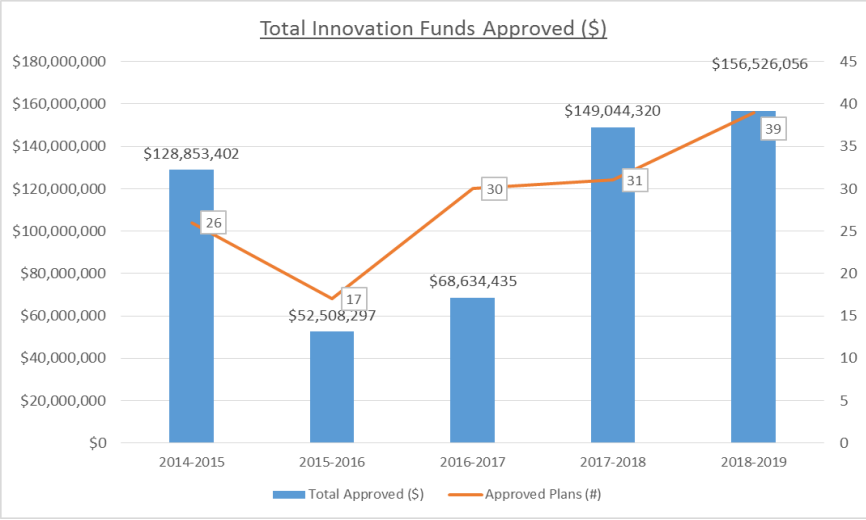
AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
52 days†

Draft → Final → Calendared

*** March:** Mono (1 Extension), Tulare (2) San Mateo (1 Extension)
April: Butte (1)

† This excludes extensions of previously-approved projects, any Tech Suite additions, and holidays.

Previous FY Trends:



Number of Counties that have presented an INN Plan to the Commission since 2013 ǂ	
55	**93%**

ǂ Number of counties that have NOT presented an INN Plan to the Commission since 2013: 4 (7%)

	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	$153,128,802
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	40
Plans that Received a Commission Vote	N/A	N/A	33	34	39
Plans APPROVED	26 N/A	17 N/A	30 91%	31 91%	39 100%
Participating Counties	16 27%	15 25%	18 31%	19 32%	26 44%

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STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	MONO	Eastern Sierra Learning Collaborative: A County Driven Regional Partnership (Extension)	$84,935.00	4 Months	11/19/2018	1/17/2019	**MARCH**
CALENDARED	TULARE	Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication	$1,610,734	5 Years	2/4/2019	1/17/2019	**MARCH**
CALENDARED	TULARE	Connectedness2Community	$1,320,684	5 Years	11/15/2018	1/17/2019	**MARCH**
CALENDARED	SAN MATEO	LGBTQ Behavioral Health Coordinated Services (The Pride Center)	$1,550,000	2 Years	1/3/2019	2/12/2019	**MARCH**
CALENDARED	BUTTE	Center CARE Project	$1,500,000	3 Years	2/4/2019	Expected 3/20/2019	**APRIL**

CALENDARED: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval steps; 30 day public comment, Local Mental Health Board/Commission hearing, and Board of Supervisor (BOS) approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	ALAMEDA	Supportive Housing Community Land Trust (CLT)	$5,000,000	8/27/2018	11/2/2018 and 2/8/2019	(PENDING)	**(PENDING)**
DRAFT	ALAMEDA	Mental Health Technology 2.0	$1,795,045	2/1/2019	2/8/2019	(PENDING)	**(PENDING)**
DRAFT	SISKIYOU	Integrated Care Project	$995,231	N/A	2/14/2019	(PENDING)	**(PENDING)**
DRAFT	VENTURA	Conocimiento – Addressing ACEs Through Core Competencies	$1,047,099	N/A	2/26/2019	(PENDING)	**(PENDING)**
DRAFT	COLUSA	Social Determinants of Rural Mental Health Project	$403,419	5/14/2018	8/30/2018	(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 and budget narrative; still may require technical assistance and is considered the last version before the FINAL is submitted

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Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

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

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

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

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

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

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

Agenda Item 6, Enclosure 6: DHCS Status Chart of County RERs Received
March 28, 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 March 15th, 2019.

This Status Report covers the FY 2012-13 through FY 2017-18 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. 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

DHCS MHSA Annual Revenue and Expenditure Status Update

	FY 14-15		FY 15-16		FY 16-17			FY 17-18		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018			
Alpine	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018			
Amador	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018	12/19/2018	12/19/2018	12/21/2018
Berkeley City	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018	12/28/2018	1/2/2019	1/8/2019
Butte	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018			
Calaveras	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018	1/10/2019		1/11/2019
Colusa	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018			
Contra Costa	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018	12/31/2018	1/7/2019	1/22/2019
Del Norte	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018	12/31/2018		1/2/2019
El Dorado	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018	12/28/2018	1/3/2019	1/25/2019
Fresno	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018	12/28/2018	1/2/2019	1/2/2019
Glenn	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018	12/31/2018	1/7/2019	2/11/2019
Humboldt	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018	12/20/2018	12/21/2018	1/2/2019
Imperial	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018	12/26/2018		1/2/2019
Inyo	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018			
Kern	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018	1/4/2019		1/7/2019
Kings	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018	1/31/2019		2/11/2019
Lake	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018				
Lassen	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018	1/8/2019	1/14/2019	1/31/2019
Los Angeles	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018	12/31/2018	1/14/2019	1/29/2019
Madera	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018	12/31/2018	1/7/2019	2/4/2019
Marin	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018	12/21/2018	12/21/2018	12/21/2018
Mariposa	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018	12/20/2018	1/3/2019	1/31/2019
Mendocino	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018	12/31/2018		1/3/2019
Merced	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018	12/21/2018	12/21/2018	12/31/2018
Modoc	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018	1/16/2019	1/16/2019	1/24/2019
Mono	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018	12/28/2018	1/3/2019	1/17/2019
Monterey	3/29/2018	4/23/2018	10/4/2018	10/4/2018	10/4/2018		10/4/2018	3/5/2019		
Napa	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018	12/28/2018	1/2/2019	1/4/2019
Nevada	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018	12/21/2018		12/21/2018
Orange	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018	12/28/2018	1/2/2019	1/31/2019
Placer	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018	1/18/2019		1/22/2019
Plumas	6/8/2017	6/23/2017	3/27/2018	3/28/2018	10/8/2018		10/15/2018			
Riverside	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/29/2019
Sacramento	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018	1/2/2019	1/2/2019
San Benito	10/24/2016	3/8/2016	9/8/2017	9/12/2017	9/25/2018		9/27/2018			
San Bernardino	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018	12/31/2018		1/2/2019
San Diego	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018	12/26/2018		1/15/2019
San Francisco	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018	12/31/2018	1/3/2019	1/30/2019
San Joaquin	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/7/2019
San Luis Obispo	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018	12/14/2018	12/18/2018	12/28/2018
San Mateo	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018	12/31/2018		1/2/2019
Santa Barbara	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018	12/21/2018	1/3/2019	1/14/2019
Santa Clara	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018	12/27/2018		1/2/2019
Santa Cruz	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018	12/31/2018	1/3/2019	1/7/2019
Shasta	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018	12/13/2018	12/17/2018	1/2/2019
Sierra	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018	12/28/2018		1/2/2019
Siskiyou	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		1/15/2019			
Solano	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018	12/31/2018	1/3/2019	2/21/2019
Sonoma	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018	1/16/2019	1/29/2019	2/1/2019
Stanislaus	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018	12/26/2018		1/3/2019
Sutter-Yuba	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018	1/7/2019	1/28/2019	1/31/2019
Tehama	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018			
Tri-City	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018	12/31/2018	1/3/2019	1/30/2019
Trinity	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018	1/30/2019		2/7/2019
Tulare	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018	12/19/2018	12/21/2018	12/26/2018
Tuolumne	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018	12/11/2018	12/12/2018	12/12/2018
Ventura	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018	12/20/2018		12/21/2018
Yolo	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018	1/30/2019	1/31/2019	1/31/2019
Total	59	59	59	59	59		58	49	30	48

* FY 2005-06 through FY 2013-14, all Counties are current

Current Through: 03/15/2019

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

2019 Legislative Report to the Commission
March 18, 2019

SPONSORED LEGISLATION

Senate Bill 12 (Beall)
Title: Mental health services: youth.

Summary: This bill would require the commission, subject to the availability of funds for these purposes, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes. The bill would authorize the commission to implement these provisions by means of an informational letter, bulletins, or similar instructions.

Status/Location: 3/13/19 Set for hearing March 27.

Assembly Bill 46 (Carrillo)
Title: Individuals with mental illness: change of term.

Summary: Current 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.

Status/Location: 12/4/18 From printer. May be heard in committee January 3.

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CO-SPONSORED LEGISLATION

Senate Bill 10 (Beall)

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

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 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.

Status/Location: 3/13/19 Set for hearing March 27.

Co-Sponsors: Steinberg Institute

Senate Bill 11 (Beall)

Title: Health care coverage: mental health parity.

Summary: 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.

Status/Location: 1/16/19 Referred to Com. on HEALTH.

Co-Sponsors: The Kennedy Forum; Steinberg Institute