



WELLNESS • RECOVERY • RESILIENCE



Commission Packet

Commission Meeting
May 23, 2019

WeRise 2019
Downtown Los Angeles Arts District
1262 Palmetto St
Los Angeles, CA 90013

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

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

May 23, 2019
9:00 AM – 4:30 PM

WeRise 2019
Downtown Los Angeles Arts District
1262 Palmetto St
Los Angeles, CA 90013

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
May 23, 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, Celeste Walley. Roll call will be taken.

9:10 AM Announcements

9:20 AM Consumer/Family Voice

Keris Jän Myrick will open the Commission meeting with a story of recovery and resilience.

9:40 AM Action

1: Approve April 25, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the April 25, 2019 meeting.

- Public Comment
- Vote

9:45 AM Action

2: Orange County Innovation Plan

Presenters:

- Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency
- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator
- Courtney Ransom, J.D., Family Member

The Commission will consider approval of \$18,000,000 to support Orange County's Behavioral Health System Transformation Innovation Project.

- Public Comment
- Vote

11:15 AM Action

3: Ventura County Innovation Plan

Presenters:

- Kiran Sahota, MA, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health
- Hilary Carson, MSW, MHSA Administrator, Innovations, Ventura County Behavioral Health

The Commission will consider approval of \$1,047,100 to support Ventura County's Conocimiento: Addressing ACEs through Core Competencies Innovation Project.

- Public Comment
- Vote

12:00 PM Lunch Break

1:00 PM Action

4: Los Angeles County Innovation Plan

Presenters:

- Jonathan Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County
- Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County
- Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center
- David Pilon, Ph.D., C.P.R.P., Mental Health Consultant

The Commission will consider approval of \$116,750,000 to support Los Angeles County's The TRIESTE Project: True Recovery Innovation Embraces Systems That Empower.

- Public Comment
- Vote

3:00 PM Action

5: Streamline Commission Approval of Innovation Plans

Presenter:

- Brian Sala, Ph.D., Deputy Director, MHSOAC

The Commission will consider options for streamlining procedures for approval of County Innovation Project work plans.

- Public Comment
- Vote

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



Transitional Age Youth Representative & Consumer Speaker

Celeste Ruth Walley, Transitional Age Youth Representative

Celeste was born in San Francisco and is currently living in San Leandro, CA. She works as a Youth Advocate and consultant at Seneca Family of Agencies. She is a Chemistry major in her fourth year at the University of California, Merced. Celeste serves as the President of the Guardian Scholars Club on her campus, a club that provides foster care outreach in Merced County. Her interest in the mental health system began when she was a recipient of services at Seneca. She has volunteered in a health center and her future goals include opening a clinic that challenges stigmas around physical and mental health and their correlations to one another. Celeste is currently serving as an MHSOAC Youth Innovation Workgroup member.

Keris Jän Myrick, MBA, MS, Consumer Speaker

Keris Jän Myrick is Discipline Chief for Peer Services for the Los Angeles County Department of Mental Health. She served previously as Director of the Office of Consumer Affairs for the Center for Mental Health Services (CMHS), SAMHSA. Ms. Myrick is a leading mental health advocate and executive, known for innovative, inclusive approaches to mental health reform as well as disclosure of her personal story. Ms. Myrick has over 15 years of experience in mental health services innovations, transformation, and peer workforce development. She previously served as President/CEO of Project Return Peer Support Network, a peer-run nonprofit; the President of National Alliance on Mental Illness (NAMI); and as a consultant to the American Psychiatric Association's Office of Minority and National Affairs (OMNA). An author of several peer-reviewed journal articles and book chapters, Ms. Myrick is an in-demand national trainer and keynote speaker. Ms. Myrick has an MS degree (industrial-organizational psychology) and an MBA degree (marketing emphasis).

AGENDA ITEM 1

Action

May 23, 2019 Commission Meeting

Approve April 25, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the April 25, 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) April 25, 2019 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the April 25, 2019 meeting minutes.

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
April 25, 2019

DoubleTree Anaheim Convention Center
Tuscany Room
2085 South Harbor Boulevard
Anaheim, CA 92802

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Mayra Alvarez
Reneeta Anthony
Ken Berrick

Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Tina Wooton

Members Absent:

Senator Jim Beall
John Boyd, Psy.D.
Sheriff Bill Brown

Assemblymember Wendy Carrillo
Gladys Mitchell

Staff Present:

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

Brian Sala, Ph.D., Deputy Director,
Evaluation and Program Operations

CONVENE AND WELCOME

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 confirmed the presence of a quorum.

Announcements

Chair Tamplen stated the Commission launched a Youth Innovation Project and engaged youth throughout the state to support the design of youth-oriented mental health innovations. The Commission has recruited and appointed fifteen members for the Youth Innovation Project. The

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Planning Committee has met and will have a teleconference meeting on May 10th. Information about this meeting is posted on the MHSOAC's website.

Chair Tamplen reviewed upcoming meetings. Information about these meetings are posted on the MHSOAC website.

- The Cultural and Linguistic Competence Committee will be meeting on May 16th in Sacramento.
- The Client and Family Leadership Committee will be meeting on May 22nd in Los Angeles.
- The 39th Annual California Mental Health Advocates for Children and Youth (CMHACY) conference is May 15th – 17th. MHSOAC staff has been invited to lead a workshop for transition age youth (TAY) coordinators about youth mental wellness in California.
- The next Commission meeting will be held at the WE RISE 2019 event in Los Angeles on May 23rd.

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. Matthew Diep, a member of the Planning Committee for the Youth Innovation Project, introduced himself.

Consumer/Family Voice

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

Jason Robison, Program Director, SHARE!, a peer-run self-help and recovery exchange, shared his story of finding self-help support groups after college where he connected with individuals who had the same experiences he did and helped him feel at home and okay. He stated hearing other people talk about their experiences and what they did to lead a fulfilling life changed his life. His mission today is to find ways to bring self-help support groups to everyone and to create a peer workforce. Mr. Robison shared several projects that he is working on, including a project with OSHPD on training peer specialists supervisors. He stated recovery is an opportunity to be of service to others.

ACTION

1: Approve March 28, 2019, MHSOAC Meeting Minutes

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Berrick, that:

The Commission approves the March 28, 2019, Meeting Minutes.

Motion carried 6 yes, 0 no, and 4 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioners abstained: Commissioners Alvarez, Bunch, Danovitch, and Gordon.

ACTION

2: Butte County Innovation Plan

Presenters:

- Heather Senske, Director of Child Development Programs and Services (CDPS), Butte County Office of Education
- Holli Drobny, Community Services Program Manager, Butte County Behavioral Health
- Yvonne McQuaid, Director, First 5 Butte County Children and Families Commission
- Shelley Hart, PhD, NCSP, Member, Planning and Development Committee for The Center
- Sherisse Allen, Consultant, Butte County Office of Education

Chair Tamplen stated the Commission will consider approval of \$1,671,031 to support Butte County's Center CARE (Collective Action for Resiliency and Education) Innovation Project. She asked the representatives from Butte County to present this agenda item.

Holli Drobny, Community Services Program Manager and MHSA Coordinator, Butte County Behavioral Health, introduced the Innovation presentation team and provided an overview of the county demographics and background of the proposed Innovation project.

Heather Senske, Director of Child Development Programs and Services (CDPS), Butte County Office of Education, provided an overview, with a slide presentation, of the need for the proposed Innovation project, project components, budget, and sustainability.

Shelley Hart, PhD, NCSP, Associate Professor, Chico State Child Development Department; Research Associate, Johns Hopkins; Member, Planning and Development Committee for The Center, continued the slide presentation and discussed the need the proposed Innovation project addressed.

Yvonne McQuaid, Director, First 5 Butte County Children and Families Commission, continued the slide presentation and discussed the components of the proposed Innovation project.

Commissioner Questions

Commissioner Anthony asked for added detail on the community input process in remote areas and about compensation for peers.

Ms. Senske stated the community input process was multifaceted. There was a Mental Health Services Act (MHSA) Innovations input process and public comment period, a series of stakeholder focus groups that included groups in each corner of the county, and an electronic and paper survey process to collect information about the needs of each community and population.

Commissioner Anthony asked how many sites were visited and how many times each site was visited.

Sherisse Allen, Consultant, Butte County Office of Education, stated there were multiple facets to the community involvement and engagement process. The eight different stakeholder groups that provided feedback were county leaders and decision makers, social service providers,

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mental health providers, educators from infant to 12th grade, college students, college professors, internship/work study coordinators, and families.

Ms. Allen stated, in addition, the county has tried to hear the voices of community members who have been historically disenfranchised and disregarded in service and community development. She stated the understanding that discrimination and bias are in and of themselves sources of individual, cultural, and community trauma; therefore, to truly serve the community, the county found opportunities to engage and see through the many cultural lenses of its community members. She listed the names of cultural organizations the county has spoken with.

Ms. Allen stated the county has conducted 16 focus groups throughout the county and received hundreds of feedback surveys, which were provided in multiple languages.

Commissioner Alvarez asked about the evaluation component and how the county will lift up the learnings of this Innovation plan so other counties can follow. She stated the need to identify more concretely the infrastructure that helps this model come alive so it can be promoted across the state and every child can have an opportunity to be connected to these services.

Ms. Senske stated the CARE project is only one component. She stated the infographic with the various dots on presentation slide 6 shows the broader concept and set of services that will happen at and from the Center for Learning and Resilience (The Center). She stated the county is preparing to launch a Help Me Grow program that will become one of the elements of the broader concept of The Center. The CARE project is one specific innovative component in order to get mental health services to remote communities. She stated the county has a variety of mechanisms to scale up and report information back.

Commissioner Gordon asked about the involvement of the school districts and school sites so they can be integrated into the project and there can be follow-through as children get into K-12 schools.

Ms. Senske stated the CARE project is the innovative component but the answer to Commissioner Gordon's question lies in the rest of how that connects with the greater work of The Center. The Center will serve children 0 to 5-year-olds/0 to 8-year-olds because there are siblings and family systems involved. There are several tiers of outcomes of work that are related to The Center and schools are a critical component of that.

Commissioner Berrick asked how child welfare will interact with the program.

Ms. Senske stated the vision of this initiative is to slowly but surely over time impact and support all related systems in the county. Representatives from all systems are being brought together to create something different from the ground up. Child welfare is part of that.

Commissioner Wooton asked about peer support personnel in the budget.

Ms. Senske stated the peer navigators will be funded through other sources since resources within the Innovations budget were limited.

Commissioner Wooton asked about the number of peer navigators the county plans to hire.

Ms. Senske stated the program will start with at least one. She stated The Center is a tremendous initiative and is being funded as it is being built. She stated she anticipated several peer support personnel will be hired to support the populations being served.

Commissioner Wooton stated that peer navigators include family members. She advocated for family member positions as well.

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Vice Chair Ashbeck stated the county has isolated communities but it is building The Center in Chico. Other than providing services in schools, she asked how individuals will have contact with The Center.

Ms. Senske stated there is a significant travel budget line item. The mental health consultants will travel across the county to early learning settings to observe children and they will be working with families and professionals directly. The Center is the hub that the consultants will come back to in order to connect with multidisciplinary team members.

Vice Chair Ashbeck suggested including the integration of physical health as another way to support families.

Public Comment

Melissa Hannah, United Parents; Parents and Caregivers for Wellbeing, spoke in support of the proposed project.

Scott Kennelly, Butte County Behavioral Health, spoke in support of the proposed project.

Ema Friedberg, Regional Director, Northern Valley Catholic Social Service (NCVSS), spoke in support of the proposed project.

Tim Taylor, Former County Superintendent for Butte County; Executive Director, Small Schools of California, spoke in support of the proposed project.

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

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA); Co-Director, #Out4MentalHealth, spoke in support of the proposed project.

Andrea Wagner, ACCESS California Ambassador; Counselor for Crisis Services, Butte County Behavioral Health, spoke in support of the proposed project.

Tiffany Carter, Assistant Statewide Advocate, ACCESS California; NorCal MHA, spoke in support of the proposed project.

Sherisse Allen, Consultant, Butte County Office of Education, spoke in support of the proposed project.

Dr. Shaun-Adrian Chofla, Professor of Education, Child, and Family Studies, Butte College; Butte County First 5, spoke in support of the proposed project.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA; Project Coordinator, #Out4MentalHealth, spoke in support of the proposed project. The speaker's one concern and recommendation to the Commission in consideration of the proposal is that the Commission ask for documentation of how much the peer providers will be paid.

Matthew Diep stated the use of these funds for this project would be wise, especially if research is used to identify the parts that are successful so they can be modeled in other communities.

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

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

Name: Center CARE Project

Amount: \$1,671,031

Project Length: Three (3) Years, Two (2) Months

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

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

ACTION

3: Alameda County Innovation Plan

Presenters:

- Tracy Hazelton, MPH, Division Director MHSA, Alameda County Behavioral Health
- Mary Skinner, J.D., Innovations Coordinator, MHSA, Alameda County Behavioral Health

Chair Tamplen stated the Commission will consider approval of \$2,040,120 to support Alameda County's Mental Health Technology 2.0 Innovation Project. She asked the representatives from Alameda County to present this agenda item.

Chair Tamplen and Commissioner Berrick recused themselves from the Alameda County Innovation plan discussion and decision-making and left the room with regard to this agenda item pursuant to Commission policy.

Tracy Hazelton, MPH, Division Director MHSA, Alameda County Behavioral Health, reviewed the background of the proposed Innovation project and provided an overview, with a slide presentation, of the county demographics and the need for the proposed Innovation project.

Mary Skinner, J.D., Innovations Coordinator, MHSA, Alameda County Behavioral Health, continued the slide presentation and discussed the proposed project to address the need.

Ms. Hazelton continued the slide presentation and discussed the innovative components, evaluation, budget, and sustainability of the proposed Innovation project. She showed a video of Gordon Reed, Pool of Consumer Champions (POCC), Alameda County Behavioral Health consumer and family member, where Mr. Reed discussed the program.

Commissioner Questions

Commissioner Danovitch asked for clarification on the definition of the term technology.

Ms. Hazelton stated the technology used for the proposed project is the use of mental health applications (apps) with Smart phones, laptops, and desktop computers for individuals in Alameda County who are experiencing situational-induced trauma.

Vice Chair Ashbeck asked for clarification that today's presentation is a continuation of the presentation at the October 2018 Commission meeting where there was a disconnect on the funding. She asked if this is a repackaging of the same project.

Ms. Skinner stated it is except the 2.0 version includes the target population of suicide survivors. The county made an administrative error in October but is now asking for permission to spend the money and to redo the Request for Proposals (RFP).

Commissioner Madrigal-Weiss stated she recently spoke to a group of stakeholders in Alameda County and she heard loud and clear that mental health issues are issues of the heart and soul. Technology was not discussed. She asked how the county engaged the refugee and immigrant populations and why the county believes they will benefit from an app.

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Ms. Hazelton stated there are language issues in the county. When the RFP was done previously, two of the nine proposals wanted to serve immigrants and refugees. She agreed that apps can be isolating, but if done in a culturally responsive way that an ethnic provider develops, it can lead to more fellowship and accessibility.

Commissioner Bunch asked if the county has reviewed the 7 Cups app or others and how the proposed project differs.

Ms. Hazelton stated she accessed the 7 Cups app to see what the California Mental Health Services Authority (CalMHSA) was doing and what the app looked like. She stated what they were doing was unclear. She stated the proposed project is looking for big specifics, such as a life box kit for suicide survivors, and has 24-hour availability.

Commissioner Bunch asked if individuals will interact with someone live.

Ms. Hazelton stated there are no live interactions. It is about user-driven support in the moment for that user. Part of recovery is keeping a journal, knowing what the signs are, and keeping track of signs and symptoms.

Commissioner Alvarez asked if Alameda County is part of the Technology Suite.

Ms. Hazelton stated it is not.

Commissioner Alvarez stated the fact that Ms. Hazelton is working on this app on a daily basis but did not understand the 7 Cups app is quite concerning.

Ms. Hazelton stated she can only get on one of the two apps that are available with the Technology Suite. The 7 Cups app did not seem like there was a significant connection. She stated this is what the county is trying to build with the proposed project – having local agencies build something for their local communities to create a connection.

Commissioner Alvarez stated it is important that the Commission identifies what the Technology Suite is doing and how to ensure that the good progress being made can be distributed to others. She stated Alameda County is giving local nonprofits a \$230,000 grant. \$110,000 of that will be subcontracted out to a technology company. She asked about the type of technical assistance that will be provided to the local nonprofits to ensure that the contract is successful.

Ms. Hazelton stated extra time was allotted during the bidders' conference for the previous RFP and invited local developers. Various meetings were held for community-based organizations to meet technology developers to see if there was a good match. There is also a test that the development must pass in order to show that they are a true developer that can code as opposed to a community-based organization picking anyone out there that may not have the necessary skills.

Ms. Hazelton stated one-fourth of Ms. Skinner's time is devoted to tracking the progress of the grantees and looking at the contracts as they come through to ensure that the community-based organizations get what they are asking for with the app.

Commissioner Alvarez stated the use of technology as a tool to address health challenges, create community, and provide supports is not new. She asked why the county chose a grant process that would leave local nonprofits to subcontract with technology companies when there are other more collaborative efforts available.

Ms. Hazelton stated this was a project from 2016 to work with technology and to honor the expertise of local community-based organizations. There were twelve bids, nine grants were awarded, and each received \$210,000. The only reason this project was brought back is

because the county receives continuous emails from the community expressing their interest and asking when it will be implemented.

Ms. Skinner stated this proposal was built on the old proposal and includes ideas taken from the RFP apps. For example, the idea of embedding came from one of the applications.

Commissioner Danovitch echoed Commissioner Alvarez's comments. There are many open questions around the development process. It is unclear in this project to what extent new tools and apps are being developed versus to what extent existing tools and apps are being adopted and, in both cases, how they will be successfully implemented. The Commission has similar concerns with the technology suite initiative. He asked what has been learned from that process so the same challenges are not repeated in engaging in the products and innovations. He stated he would love to see counties learning from these Innovations and using that learning to inform improvements but he does not see the crosstalk between the two.

Ms. Skinner stated the previous project opened the county's eyes on the problems that existed, such as understanding privacy rules, regulatory laws that were around it, and what is considered a medical device. The original RFP did not address these things. The applicant organizations wanted to bring mobile apps into their own services and to take what they are already doing and level it up. She stated the technology suite's report from last year included a page of what is legally required but did not include the steps they took to get there. She stated the learning process is ongoing and the county continues to work under the advisement of county counsel and receives input from the community-based organizations that are interested in doing this project and are in contact weekly asking about the status of this project.

Commissioner Wooton stated the need to interface with other counties and share what is learned.

Matthew Diep stated students have to wait three to four weeks to get on-campus services at UCLA. By the time students who are in crisis see a therapist, their condition can be much worse. He stated UCLA looked at over 1,000 local apps for students to use during that three- to four-week period as a crisis management tool. He agreed that the use of an app itself is not innovative but it is how they are used that can be innovative.

Mr. Diep stated there are many good reasons why these apps could support community-based organizations. For example, individuals who doubt the effectiveness of these organizations can get a sneak peek through the app of the types of services that are available without being fully committed, apps are generally less expensive, and individuals can remain anonymous. Also, the technicians can receive a lot of day-to-day patient data through the apps so appointment time is spent more efficiently.

Mr. Diep suggested, based on the apps UCLA has worked with, it may be better to work with one of the apps that has already gone through the academic research process rather than trying to build something from scratch, which will take time and money.

Public Comment

Max Geide spoke in support of the proposed project.

Thaddeus Dickson, CEO, Xpio Health; Bonita House, spoke in support of the proposed project.

Tiffany Carter stated concern that there were 18 focus groups identified as being addressed for this program. The speaker asked about the number of individuals who were touched within those focus groups and how much of the community was involved. The speaker asked if the security measures were addressed in partnership with stakeholders, specifically consumers. The speaker stated the general standards for client-driven and family-driven are combined in

the plan but need to be separate. Also, the general standards need to be reflected throughout the entire program – creation, implementation, evaluation, and revision.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated Alameda County serves diverse communities. The speaker reminded the Commission that these grants were already awarded by the county. The county asked for an exemption because of a technicality but the Commission denied it so the county went back and did what the Commission asked.

The speaker also reminded the Commission that 7 Cups presented twice before the Commission and, although they were asked to come back to demonstrate diversity in their program, they were unable to do that. The speaker referred to the Commission's request for the county to work with CalMHSA, and stated the individuals in Alameda County trust Alameda County more than they do CalMHSA and 7 Cups. The Commission has requested including local organizations over the state and that is what was presented today.

Poshi Walker stated concern surrounding the use of apps as an intervention. Since one of the concerns is that many of the people this project targets do not know about or think they need services, the speaker asked why these individuals would be motivated to download and use an app. The speaker asked, if the need is outreach and education about services, how individuals will learn about these apps. The speaker suggested using those resources to instead educate them about in-person services. The speaker stated concern about who will have the capacity to develop competent apps in two years with such limited funding and if the same for-profit companies now being funded by the Technology Suite Innovation Project will be funded with even more MHSOAC dollars.

Poshi Walker stated the answer to Vice Chair Ashbeck's question was confusing. The speaker questioned how the user will get feedback if there is no live support or electronic support. Somehow there needs to be feedback or the user is just creating an electronic journal, which is not innovative or helpful. The speaker stated research has shown that the majority of individuals who access apps of this kind are under 30 years of age. The speaker asked how adults over 30 benefit from this project.

Rory O'Brien spoke in firm opposition to the proposed project primarily for the lack of detail regarding client protection and the evidence base for the design. The speaker stated concern about how the data will be used and how the data of consumers will be safeguarded. The speaker was confused by the design of the app and, as was mentioned by the previous speaker, by the lack of both a live responder and by a robo-responder. The speaker questioned how the app will work. The speaker cautioned against consumers speaking into a void and questioned who will respond to the app users, how quickly, and with what expertise.

Rory O'Brien stated discussion on an app may be helpful for someone who is experiencing anxiety or depression, but daily check-ins and chat are wholly insufficient to respond to trauma and yet this tool is intended for individuals living with trauma. Evidence-based practices to treat trauma and post-traumatic stress disorder typically involve person-to-person intensive interventions that frequently utilize both body and mind connections to move trauma and to effectively treat it. The practices go completely unmentioned.

Rory O'Brien stated building community connections can be used to prevent suicidality and to build resiliency after an attempt, but the vague descriptions of this technology and the unavailability of a live person do not facilitate local meaningful community connections. The speaker stated suicide attempt survivors, youth living with trauma, refugees, and immigrants deserve strong intensive services to address their needs. Technology may help get people in the door and it may indeed be instrumental in the context of an intervention such as eye

movement desensitization and reprocessing (EMDR), but it cannot and should not be the extent of interventions with these vulnerable populations.

Commissioner Discussion

Commissioner Anthony stated the Commission had asked Alameda County to come back. They have an understanding to move forward within their community. She made a motion for approval.

Commissioner Madrigal-Weiss made a second.

Commissioner Alvarez agreed and stated she felt the Commission would be punishing Alameda County just because they did not understand what the Technology Suite is doing. The Technology Suite has consistently been an area of challenge for the Commission to understand. She asked to invite the representatives from the Technology Suite to a future Commission meeting to better prepare the Commission for when technology proposals are presented.

Matthew Diep stated mobile apps are scary because face-to-face interaction is taken away, but the proposed project sounds like the county is trying to strengthen interactions by adding technology to improve it. He suggested looking at an app that has already been developed and has gone through clinical testing.

Vice Chair Ashbeck directed staff to work with the county on quality control measures. She stated she does not have confidence in the skill or experience of the eight developers who will develop these apps. She stated UCLA looked at over 1,000 apps; eight more will not make a difference. She asked staff to comment.

Executive Director Ewing stated the county is working through their legal counsel and with their community experts to ensure that they are meeting requirements. Like many Innovations, these are topics that the Commission does not have the internal expertise on. He stated, quite often with this work, the Commission is on the front-end side of approving a budget. There is not time to manage the implementation and monitor it.

Executive Director Ewing stated staff could work with Alameda County, CalMHSA, CBHDA, private sector organizations, academic and technology partners, and all the counties that are exploring apps to partner to bring individuals together to get a sense of the key issues and challenges that the Commission should be thinking about as these proposals come along with the understanding that the public sector is not always at the forefront of this work. The opportunity of technology should be leveraged in ways that are comfortable.

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

The Commission approves Alameda County's innovation project as follows:

Name: Mental Health Technology 2.0

Amount: Up to \$2,040,120 in MHSA INN funds

Project Length: 2.5 Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Gordon, Madrigal-Weiss, and Wooton.

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

Chair Tamplen and Commissioner Berrick rejoined the Commissioners at the dais.

ACTION

4: Awarding of the Immigrant and Refugee Stakeholder Contracts

Presenters:

- Norma Pate, Deputy Director, MHSOAC
- Tom Orrock, Chief of Commission Operations and Grants, MHSOAC

Chair Tamplen stated the Commission will consider awarding stakeholder contracts to five organizations for a total amount of \$2,012,500 to the highest scoring applicants for the Immigrant and Refugee Stakeholder Request for Proposal. She asked staff to present this agenda item.

Norma Pate, Deputy Director, MHSOAC, stated staff received 46 Letters of Intent that covered approximately 93 targeted populations from 40 counties over the five California regions through the Immigrant and Refugee Stakeholder Contract RFP process. Staff is working with the Legislature to secure additional funding to support the unmet mental health needs of these communities.

Tom Orrock, Chief of Commission Operations and Grants, MHSOAC, provided an overview, with a slide presentation, of the background, RFP timeline and evaluation process, and a summary of the different counties represented by the applicants, and the results of the RFP for the Immigrant and Refugee Stakeholder Contracts. He announced the highest scoring proposer from each region as follows:

- Superior Region – Hmong Cultural Center of Butte County
- Central Region – Healthy House within a Multidisciplinary Approach to Cross-Cultural Health (MATCH) Coalition
- Bay Area Region – Vision y Compromiso
- Southern California – Boat People SOS (BPSOS)
- Los Angeles – African Communities Public Health Coalition (ACPHC)

Public Comment

Stacie Hiramoto asked the Commission to reconsider its decision to eliminate statewide advocacy for refugees and immigrants in this grant.

Poshi Walker reminded the Commission that almost all, if not all, of the public comment around how to shape this RFP emphasized the importance of having a statewide contract for refugees and immigrants for technical assistance and statewide advocacy. There is also a need for federal advocacy. The speaker asked about the progress of the funding for the statewide contractor and assurance that this will happen.

Ms. Pate stated staff is currently working with the Legislature to seek additional funding for these populations.

Action: Commissioner Anthony made a motion, seconded by Vice Chair Ashbeck, that:

For the organizations with the highest scoring proposals from each region, staff recommends the Commission:

- *Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to the highest scoring proposer from each region:*

Region	Organization
Superior	Hmong Cultural Center of Butte County
Central	Healthy House within a Multidisciplinary Approach to Cross-Cultural Health (MATCH) Coalition
Bay Area	Vision y Compromiso
Southern	Boat People SOS (BPSOS)
Los Angeles	African Communities Public Health Coalition

- *Establish May 2, 2019 as the deadline for unsuccessful bidders to file an "Intent to Protest" and May 9, 2019 as the deadline to file a letter of protest consistent with the requirements set forth in the RFP.*
- *Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.*
- *Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.*

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

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

ACTION

5: Legislative and Budgetary Priorities

Presenter:

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

Chair Tamplen stated the Commission will consider legislative and budget priorities for the current legislative session. She asked Executive Director Ewing to introduce this agenda item.

Executive Director Ewing stated the bill summaries and analysis were included in the meeting packet for the following bills:

- Senate Bill 66 (Atkins) Medi-Cal: federally qualified health center and rural health clinic services. This bill is consistent with PEI.
- Assembly Bill 512 (Ting) Medi-Cal: specialty mental health services. This bill is consistent with the work the Commission has done on reducing disparities and with the PEI regulations.

- Assembly Bill 1352 (Waldron) Community mental health services: mental health boards. The Commission supports the local boards and commissions association. This bill deals with the concern that there are barriers between the local boards/commissions and the Boards of Supervisors.

Commissioner Questions

Commissioner Alvarez referred to Assembly Bill (AB) 512 and asked if staff is in conversation with the Department of Health Care Services (DHCS) to learn ways in which the Commission can partner in this effort given the results of the audit from last year.

Executive Director Ewing stated staff is in conversation with the DHCS but not specifically on this issue.

Commissioner Alvarez asked if the bill language reiterates the message of consultation with the Commission.

Executive Director Ewing stated not in that area but staff has raised this issue as an area of oversight with the Legislature.

Commissioner Gordon referred to AB 1352 and asked, given the great variance in the way counties approach managing their behavioral health departments and how they treat these boards it is known how this would uniformly work across the state. It is unknown if the bill would just muddy the waters more.

Executive Director Ewing agreed. He stated much of the bill is advisory and encourages counties to provide funding to staff their boards and make them more independent. As with many areas of public policy, the Legislature is signaling intent without encroaching on the discussion and independence of counties. Much of it is encouraging, strengthening, and trying to highlight the value of the local boards without encroaching on the unique authority of the boards of supervisors.

Commissioner Gordon stated the board of supervisors appoints the members of the mental health board and they hire the employees of the behavioral health department. He stated this is a bill he would recommend staying away from to keep from putting out a false promise that this will make things better across the state.

Commissioner Danovitch asked about policy landscape analyses or other ways to understand the categories of current legislative actions to help Commissioners to be effective and identify gaps.

Executive Director Ewing stated staff is tracking approximately 100 mental health bills and presents bills to Commissioners for possible support that are consistent with decisions Commissioners have made. Staff also responds through technical assistance to requests from the Governor's office or the Legislature that is independent of the Commission having a position. He stated it is difficult to provide landscape analyses because bills change daily. He stated staff tries to focus Commissioners' time and energy into policy projects so that the Commission is using its time to set the agenda more than respond to it.

Public Comment

Stacie Hiramoto spoke in support of Commissioner Danovitch's comment. The speaker recommended that there be a legislative committee because taking positions on bills is important. The speaker spoke in support of AB 512 and SB 66. A letter with the speaker's full comment was sent to the Commission.

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Carolina Valle, Policy Manager, California Pan Ethnic Health Network (CPEHN), stated CPEHN is a co-sponsor of AB 512. The speaker spoke in support of AB 512.

Weiyu Zhang, Health Program Educator, Asian Americans Advancing Justice, Los Angeles, spoke in support of AB 512.

Ana Avendano Torres, Mixteco Indigena Community Organizing Project/ El Proyecto Mixteco / Indígena Organización Comunitaria (MICOP), spoke in support of AB 512.

Lidia Lopez, MICOP, spoke in support of AB 512.

Charlene Choi, Director of Strategic Development, Korean Community Services, spoke in support of AB 512.

Melissa Hannah spoke in support of SB 66.

Poshi Walker spoke in support of AB 512.

Poshi Walker stated all the concerns about the county Cultural Competency Plans moving to the DHCS have come to fruition. This work has ceased happening. The DHCS has not provided updated guidance to counties or reviewed plans since 2010, when it received its authority.

Rory O'Brien spoke in support of AB 512. The speaker agreed with Commissioner Danovitch's comments and with Stacie Hiramoto about the Commission convening a legislative committee.

Jane Adcock, Executive Officer, California Behavioral Health Planning Council (CBHPC), stated the CBHPC agrees with and promotes the reducing of disparities and setting performance targets but has not yet taken a position on AB 512. The speaker is working with the sponsors of AB 512 on the following concerns:

- The required monthly meetings would be onerous and unfruitful.
- The DHCS does not have enough responsibility in this area. Counties submit their Cultural Competency Plans and receive no response from the DHCS. The Office of Health Equity's expertise should be brought to bear on this.

Steve Leoni, consumer and advocate, spoke in favor of AB 1352 and agreed with Stacie Hiramoto's suggestion about the Commission convening a legislative committee.

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC supports Senate Bill 66.

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

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

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

The MHSOAC supports Assembly Bill 512.

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

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

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

The MHSOAC supports Assembly Bill 1352.

Motion carried 5 yes, 3 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Danovitch, Madrigal-Weiss, and Wooton.

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

The following Commissioners abstained: Commissioner Bunch and Chair Tamplen.

LUNCH BREAK

INFORMATION

6: Executive Director Report Out

Presenter:

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

Chair Tamplen stated Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission. She asked Executive Director Ewing to present this agenda item.

Executive Director Ewing presented his report as follows:

Budget Priorities

The Commission has asked staff to advocate for additional funding for stakeholder advocacy dollars on behalf of immigrants and refugees. Staff is working through the budget process to do that and has made that request to the Senate and Assembly Budget Committees.

Staff has been working with the Senate and Assembly Budget Committees for the Governor's proposed investment of \$25 million for early psychosis to come to the Commission rather than the DHCS consistent with the work the Commission has been doing on early psychosis.

Staff is seeking to secure the funding for the Innovation Incubator on an ongoing basis that was currently received as one-time funding.

Staff has asked the Legislature for additional staffing to help develop a strategic initiative around prevention and early intervention (PEI) programs to implement SB 1004 which was enacted last year.

Staff has asked the Legislature for additional funding and staffing to strengthen the work on data to tell a more complete picture of the mental health system in terms of dollars, programs, and outcomes.

Staff has asked the Legislature for \$5 to \$10 million annually for technical assistance. These funds would allow the Commission to invest in strategies on some of the high-priority areas.

Staff is working with the Legislature to restore the \$12 million that was cut out of triage last year.

Communication

A consultant has been engaged to help translate Commission materials into Spanish.

Office Expansion

Staff is talking with the Real Estate Division of the Department of General Services (DGS) about the Commission taking over the other half of the floor. Upon approval, staff will begin the process of expanding the office space.

Project Updates

Criminal Justice and Mental Health

Staff has been working with counties to identify projects they would be interested in co-investing that are focused on using data to better understand the involvement of individuals with mental health needs in the criminal justice system locally, strategies to strengthen Full Service Partnerships, and ways to facilitate strategies that would support prevention and diversion such as use of psychiatric advance directives.

Schools and Mental Health

This project is in the drafting phase. Staff will work with Commissioner Gordon and will convene a meeting with the subcommittee to present a draft of the Executive Summary within the next few weeks.

State Suicide Prevention Plan

Staff is working with Commissioner Wooton to review the draft of the State Suicide Prevention Plan. A full draft of that report is planned to be available to the Commission for consideration in the next few weeks.

Transparency Suite

The Transparency Suite has been launched. The Legislature has been very supportive. Staff has been asked to present it to the Senate Budget Committee.

Commission Meeting Calendar

A site visit is planned to Orange County on May 14th to learn about the Be Well Orange County Initiative prior to the May Commission meeting. The Be Well OC is an exciting multisector collaboration, an ambitious response to a longstanding challenge in Orange County.

The next Commission meeting will be in Los Angeles on May 23, 2019.

The Los Angeles Commission meeting will coincide with Los Angeles's significant two-week youth mental health initiative called WE RISE. They are providing space for the Commission to meet to learn about their WE RISE event, which involves art, culture, music, and strategies to address stigma and engage young people around mental health.

Commissioner Questions and Discussion

Commissioner Danovitch suggested restructuring the Commission meeting agenda for better time management. He suggested scheduling less time to approve Innovation plans by perhaps utilizing a consent agenda so Commissioners could pull out items to discuss. This restructure would increase effectiveness by allowing more time to discuss ways to impact the Commission's broad goals.

Executive Director Ewing stated, between delegated authority and a consent process, there may be pathways to rethink the time utilization for the Commission. He asked about the best

way for staff to help Commissioners think this through. It is important that Commissioners are in agreement about the role of Commissioners, staff, and a consent calendar.

Chair Tamplen stated Commissioner Danovitch's suggestion will be put on the May meeting agenda.

Public Comment

Stacie Hiramoto asked, if the Commission will have a major change, such as having a consent calendar, that stakeholders receive ample time to look at the new written procedure. The speaker stated the need to think about receiving input from the community, particularly consumers, family members, and individuals who represent underserved communities on these issues.

Stacie Hiramoto stated, when staff makes requests from the Legislature for the budget process, the Commissioners and the public should know prior to the request for funds. It should be transparent and in writing

Poshi Walker endorsed the idea of having a legislative committee to assist Commissioners in understanding legislation. The speaker suggested using the Innovation Subcommittee as a route to preview some of the Innovation work the Commissioners have to do.

Poshi Walker stated the Schools and Mental Health Report, which is due in June, was originally going to be about young children and NorCal MHA did their LGBTQ outreach with that in mind. The report has now been extended through 12th grade but that happened after the NorCal MHA community stakeholder process was completed. The speaker asked for an extension for the report to allow community organizations to gather the consumer, family, and stakeholder voice for 6th through 12th graders. Those voices have not yet been heard.

Rory O'Brien echoed Poshi Walker's request for an extension for the Schools and Mental Health Report considering the change in its scope. The speaker spoke in support of a consent agenda for Innovation projects, but wanted to ensure that the process does not limit public engagement in the decision-making process.

Rory O'Brien is a member of the UCLA Population Level Outcome Measures Research Study stakeholder group. The stakeholder group has had two meetings and there is still a general level of confusion over the task of the group. The speaker stated the hope that the group will be a productive use of time in advising the project. Because of that confusion, members of the stakeholder group requested and were denied a logic model to explain the purpose of the project and its outcomes so the group will be more effective. The speaker again requested the logic model to help members understand how to more fully engage in the process.

Commissioner Discussion

Commissioner Gordon stated the idea of convening a legislative committee continues to come up in public comment. He stated his concern that there are hundreds of bills around health care like there are with education and most of them deal with tiny fragments of the system. He stated, in bodies he has participated in where there is a legislative committee, the propensity is to hear many bills because now there is a committee and the committee then makes recommendations on those bills to the Commission, but the full Commission still does not have a full understanding of the impact of these bills.

Commissioner Gordon stated he would be more comfortable if the Commission limited bills to the big ideas, the big shifts and changes that are needed in the overall system, and then let the staff bring forward bills that had a likelihood to have a significant impact. The Commission would discuss them as a full group in terms of what would really make a difference. Convening a

legislative committee brings the possibility of getting lost in the details when the role of Commissioners is to make decisions on big changes and shifts in the overall system.

Commissioner Berrick stated vetting every mental health bill would take a tremendous amount of time, but if a process could be used to narrow a legislative committee's scope to bills that impact the Commission, the Committee could hear public comment and forward bills to the Commission in a consent calendar format.

Executive Director Ewing stated he would be happy to work with Commissioner Berrick on this. The challenge is issues that are on the margin – where something is consistent with something the Commission is trying to do but has not formally taken a position on. Staff is looking for a balance.

INFORMATION

7: Strategic Planning

Presenters:

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

Chair Tamplen stated the Commission will continue its Strategic Planning process facilitated by Applied Survey Research. The Commission will engage in a facilitated discussion around the organizational roadmap and results-based-planning. She asked Executive Director Ewing and the representatives from Applied Survey Research to present this agenda item.

Executive Director Ewing stated he asked the Applied Survey Research team to help Commissioners think simultaneously about the notion of moving more aggressively towards wellbeing through the kinds of activities that the Commission spends its time on in order to find a balance between the immediate kinds of activities around things like oversight of a particular program or an evaluation, as well as opportunities to do things like frame out what Workplace Mental Health might look like and support that as a broad strategy for the onset or escalation of a mental illness.

Susan Brutschy, President, Applied Survey Research, stated today the Commission will take a couple of leaps ahead to get to the results. This is a results-based strategic plan. The results can be the way the Commissioners speak together and can know that the aims being sought are being achieved.

Ms. Brutschy provided an overview, with a slide presentation, of the Strategic Plan Process Map Summary, recap of the strategic planning process to date, next steps, and changes made to the Theory of Change/Organizational Roadmap. She asked Commissioners for feedback on the changes made to the Organizational Roadmap.

Commissioner Input on the Expanded Organizational Roadmap

Commissioner Gordon stated the team did a nice job in capturing Commissioners' input. He stated his overall reaction is that it is an awful lot and he wondered how the Commission will execute on it all. The policy projects alone are a significant undertaking. He asked how the Commission will deliver on what it promises. He asked, if the Commission wants it to be what it is promising to be, how to stage it so that expectations are not raised that this can be done in a predictable period of time of two to three years and what should be worked on first.

Executive Director Ewing stated that is the key point. He stated it is not the expectation that the Commission will achieve this over the next three years. It is the framework that will guide the decisions about how the Commission's time, staff, and dollars will be used.

Commissioner Gordon stated the need to know who its constituencies are and test this on the various constituencies to see if there is consensus on priorities.

Commissioner Anthony drew everyone's attention to a sentence on the bar at the top of the Organizational Roadmap that states "... to affect change in access, quality, and appropriateness of care in three arenas...." She stated one of the things she received this week as a part of her MHSOAC subscription was a public information announcement on the transparency tool.

Commissioner Anthony stated the transparency tool talks about disenrollment reasons statewide – 9 percent of disenrollment is due to detained, jailed, or in an institution, 12 percent is moved or deceased, and 40.1 is partner discontinued/criteria not met or lost. She shared that her son is lost in the system. He receives his medication but no one makes the effort of coinciding his visit by a peer consumer with his injection of medication to talk to him. She stated that seems like it would be the easiest thing. Instead, her son has been lost.

Commissioner Anthony stated the importance of quality. She suggested including the word "quality" in the "so that" circle in the third column of the Organizational Roadmap so it will read "Everybody who needs care gets quality care when and where they need it." Quality is what is important for everyone. It should be emphasized. Looking at the loss of individuals in the system is a good way of measuring quality.

Chair Tamplen referred to the seven items listed on the Organizational Roadmap under the heading in the blue box "California's population will be better off, with reductions in" and asked to add an eighth item – ensuring that older adult neglect, isolation, and abuse is reduced too. It is important to consider how to target across the age span and not to forget older adults.

Commissioner Danovitch stated where the theories can be put to a practical test is in the green boxes in the middle column of the Organizational Roadmap, which contain actions to be taken. Each of the bullet points are goal statements that can justify their own strategic plans. The action statements start to raise questions on how those goals can be reached. Not everything can be done at the same time. This is where the Commission has to begin to manage tradeoffs and differences in priorities and realize that not everyone will agree with every decision. The Commission needs to decide about sequencing, choosing the most important goals, and near-, intermediate-, and long-term strategies to reach those goals.

Commissioner Alvarez stated the Organizational Roadmap is too high-level to determine what to do with it.

Commissioner Bunch agreed and stated it is overwhelming. She cautioned the Commission against doing too much and spreading itself so thin that it ends up doing nothing. It is important to set goals and achieve them.

Commissioner Madrigal-Weiss agreed and suggested breaking down the steps to reach each of the bullets in the green boxes in the middle column of the Organizational Roadmap. It is important to follow them through.

Commissioner Berrick stated quality is implicit here but not explicit. This is a problem because, when it is not explicit, meeting the goal is putting out X-number of useless units of service. Finding ways to link those to goals and outcomes in a clearer way is important. Also, the relationship between staff and the Commission in terms of these tasks makes that less overwhelming because the Commissioners will not do most or any of these things. The question

is what the Commissioners' role is. He stated he was pleased that staff feels they have the capability to do this but some assurance of how this will happen would be helpful.

Commissioner Berrick asked how the Commission can hold itself accountable to a series of outcomes that ensure things like quality and impact.

Executive Director Ewing stated the last section lays out the functions that the Commission is already doing and points out that the Commission is aggressively focused on the public mental health system and the MHSA dollars in the mental health system, but what the Organizational Roadmap is trying to say is the public mental health system is larger than the MHSA dollars and, if the Commission is focused on service delivery, it makes sense with the public dollar.

Executive Director Ewing stated the Commission also needs to be thinking about the larger population and leveraging the private sector. If the Commission does that, then it is the idea of ensuring appropriate quality care focusing on the outcomes that are listed in the MHSA. This is very close to reaching the end goal of wellbeing for all.

Executive Director Ewing stated the intent is not to say that the 30 MHSOAC staff can accomplish every task listed. It is the idea that this framework allows the Commission to revisit what is being done with its time and resources. It may be that the sustainability of some of the items listed on the Organizational Roadmap need to be reconsidered, potentially revisiting how Commissioners use their time and thinking more expansively about opportunities and potential partnerships. Wellbeing is not expected to be achieved in the next three years, but the idea is that this is a framework that allows the Commission to set strategic priorities for what it will be getting done.

Ms. Brutschy stated Applied Survey Research has been listing what needs to be done and Executive Director Ewing has been listing the ways to get there. Some of the opportunities to make good on the promise and spirit do have a bearing on the different ways that the Commission can partner. In each one of those relationships there are different types of partnerships. She asked Executive Director Ewing to speak more about that.

Executive Director Ewing stated the intent language of the policy side of the MHSA on the public sector is expansive. There are opportunities through Workplace Mental Health to leverage partnerships with the private sector through Commissioners' leadership and engagement. Staff has been speaking with large employers in both the public and private sectors about how to engage them and have a conversation about the opportunities they have through their purchasing power, the way in which they deliver services to their employees, or how they support anti-stigma strategies.

Executive Director Ewing stated part of that conversation when first discussing the legislation was the idea of establishing a standard for Workplace Mental Health, such as a sticker on the door. This would be a tremendous no-cost anti-stigma strategy. The original thinking behind the Commission was to leverage those kinds of partnerships.

Executive Director Ewing stated, increasingly, county behavioral health directors are thinking that not only are they delivering publicly-funded programs, but they are trying to think about the mental health of their community.

Executive Director Ewing stated the first conversation with Commissioners in the beginning of the strategic planning process was to consider ways in which the Commission can set and implement the agenda. The Commission's relationship with the Legislature is evolving. Staff is more active in talking with the Governor's office and the Legislature around policy issues and trying to set and promote that agenda through the Legislature, and has a long-standing partnership with county behavioral health directors.

Executive Director Ewing stated the Operational Roadmap is meant to highlight the potential for the Commission to think about the best use of its time in leveraging those partnerships. A tremendous amount of time is currently spent approving funding rather than following that program through. He stated he would be excited for the Commission to think about how to facilitate connections between the individuals who are building apps and the individuals who are trying to address mental health needs, rather than staff trying to pick and choose which app is the right one for a given population. Staff does not have the capacity to assess who has met standards but staff can facilitate and bring groups together such as county mental health and local schools. There are many ways to partner with different sectors that have not yet been discussed in ways that will have the impact of driving quality into the system.

Executive Director Ewing stated the hope to never give up on the outcomes work of the Commission because it is core to public accountability, which is ensuring that the public understands what they are getting for their money and then using that information to shape investments and strategies to improve it.

Ms. Brutschy stated, when everything is organized in the architecture of accountability, there is an explicitness about what this group is in for and what they promise to deliver versus what they are in a support role. The possibility to make it explicit, to say these are the outcomes that the Commission will seek and this is what those outcomes are depended upon, is the benefit of being broad and narrow at the same time.

Commissioner Alvarez stated having the role of convener is important; however, part of the benefit of being a partner is only possible when valued as a partner. She asked if many of the goals that are in place cause organizations in the public mental health system, population health, or the private sector to value the Commission in what it can bring to the partnership and, if not, if there are gaps or barriers that the Commission must overcome to make that clear. She asked if the DHCS looks to the Commission as a body of expertise that will strengthen their work to better meet the shortcoming that the audit identified or to better meet the Governor's agenda on early childhood mental health. She asked how the Commission can position itself to make the value it brings to partnerships clear.

Executive Director Ewing stated the Commission has to earn it. It must create the demand and respond to it such as was done for the data transparency project. That model lends itself to future priority areas.

Commissioner Berrick stated, when he talks to individuals in his community about the most impactful things that the Commission has done, the transparency work is what comes out for everyone. He stated knowing what it is the Commission does and how that is distributed will have impact. He stated the work of creating a contract is an enormous barrier to small counties because they often do not have the infrastructure to do cost reports and create the contracts. The Commission can have tremendous value by facilitating those kinds of processes.

Commissioner Wooton stated some of the same issues continue to arise since before the MHSA was put in place 20 years ago. She stated 20 years ago individuals were concerned with transportation, housing, employment, suicide prevention, and cultural competency. Some of those issues are embedded in the Organizational Roadmap, even in the Workplace Mental Health standards. She stated the hope that the Commission will look at agencies that support individuals who have psychiatric issues and find ways to employ consumers and family members. She stated the hope, when looking at these, that they can be broken down into the issues that the stakeholders speak about every day and at every meeting. Commission policy projects bring help to those areas.

Commissioner Wooton stated, although she understands that the private sector is an area for the Commission to grow awareness of and having anti-stigma campaigns and signs that help reduce mental health stigma is important, she worries about the private sector because, when the MHSA was first funded, everyone and every agency was there at the table asking for money. She stated the hope that that does not take away from the service aspect of the MHSA for clients.

Commissioner Wooton stated the Commission gets reports from its contract agencies and has community forums and focus groups, but she stated the hope that the Commission will continue to gather information throughout the strategic planning process from the individuals who have boots on the ground doing the work.

Commissioner Anthony spoke in support of Executive Director Ewing's comments about looking to the future for Commission partners and seeing that it is not limited.

Lisa Colvig, Vice President of Research, Applied Survey Research, continued the slide presentation and discussed the development of the Results Framework. She stated if the Operational Roadmap is the theory of change, then the Results Framework is the evaluation plan. Stated another way, the Operational Roadmap is the scope of what the Commission cares about and the Results Framework is how the Commission can show that with outcome statements and measurables. Knowing what the Commission is contributing and knowing what the expectation is about what will happen helps to define how to communicate and leverage opportunities.

Executive Director Ewing stated the hope that, after today's conversation, staff will have a strong enough sense of where the Commissioners and their desires are that Commissioners could ask staff to work with Vice Chair Ashbeck to do a draft strategic plan with a corresponding revised set of rules of procedure for Commissioners to then consider. He stated, before that can happen, Commissioners need to indicate that the Operational Roadmap and Results Framework are close to their expectations.

Ms. Brutschy stated she not only wanted input from Commissioners but from stakeholders in a mixed session. She asked Commissioners and stakeholders to separate into four mixed, facilitated groups to provide feedback on anything that is missing and about the end result of wellbeing for all.

Executive Director Ewing suggested that since there were so few members of the public in attendance it may work better to stay together as one group to allow stakeholders time to reflect and ask questions.

Public Comment

Poshi Walker suggested including less information on presentation slides; they are difficult to read on the screen and on paper. Also, colors do not work.

Poshi Walker stated the Commission agendas are overfull; a solution needs to be found.

Poshi Walker stated the idea for the legislative committee was to review bills identified by staff that may be important to the Commission and bring back concise information, concerns, and suggestions to the full Commission.

Poshi Walker stated Welfare and Institutions Code, section 5846(d), states "the Commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations."

Poshi Walker stated appreciation that, in general, the Commission is good about allowing the public to speak, that the Commission has stopped the behavior of interrupting the public while they are speaking because that is not legal, and that the public does not suffer consequences after making a public comment because that is uncomfortable, but the speaker has noticed that some stakeholders make a lot of public comment that is not reflected in Commission discussion. The speaker used the refugees and immigrants RFP as an example. Almost every public comment requested including a state contract, yet the one recommendation the public had requested not to do was the one approved. Eight people from diverse populations made that recommendation but it was not even discussed prior to the vote. The speaker stated the issue about not interrupting the public has gone to the other side. The speaker does not feel heard.

Steve Leoni thanked Commissioner Anthony for adding the word “quality” to the sentence “everybody who needs care gets care when and where they need it.” Counties typically only serve approximately 50 percent of the individuals they want to serve. Quality and appropriateness are listed in the yellow and green boxed columns but drop off at the circled sentence. It is all about access in the end.

Steve Leoni stated there were many psychiatrists that worked on the MHSA that amounted to a transformation and revolution in clinical care – a different way of doing things. The speaker stated good access will never be achieved until time and money stop being wasted on unexamined assumptions of quality and appropriateness. What is done and how it is done will not bring transformation unless what is done and how it is done is changed.

Steve Leoni stated recovery is not just about being well, meaning better; recovery is about identity, getting over the wounds of the stigma, of the pain of having this, or of being a 2nd, 3rd, or 5th class citizen. The speaker stated there was a group of consumers who went to Korea to learn about recovery; after some discussion, they concluded that recovery is getting a person’s humanity back. Instead of the slogan “housing first,” it should be “identity first.” Individuals always have to work around whatever illness they have. They may never cease to have difficulties and may need accommodations, but they will know that they are a valuable human being and they are able to contribute at whatever level they are.

Rory O’Brien echoed what Poshi Walker shared about the feeling of not being heard. It hurts to share hopefully insightful, meaningful, and helpful information regarding the things the Commission is considering and feel unheard and undervalued. The speaker stated the many advocates in the room who attend Commission meetings on a regular basis care about what the Commission does and hope that the Commission hears them and takes their words into account.

Rory O’Brien stated the models presented today are not coherent. The inputs do not follow into activities, the activities do not follow into outputs, and the outputs do not follow into short-, mid-, and long-term goals. At some point, the Commission will need to consider the quality of the contract that is being paid for and whether they want to continue pursuing it.

Stacie Hiramoto stated the blue box on the left side of the Operational Roadmap lists “client, consumer, and family involvement” but should say “consumer and family community-driven,” which is the value of the MHSA. The speaker stated the principle of “consumer and family community-driven” is being lost in the state overall.

Stacie Hiramoto stated the blue box on the left side of the Operational Roadmap also lists cultural competency, which is fine, but it should at least point to reducing disparities.

Stacie Hiramoto thanked Poshi Walker for clearly stating how stakeholders feel. The speaker stated stakeholder involvement in the process compared to in the past is less, not as powerful,

and has less transparency. The Commission is doing more work, which is great, but it is difficult for stakeholders to keep up with what the Commission is doing. The speaker stated stakeholders hear about big projects the Commission is undertaking at Commission meetings, not in the Committees, which is an issue.

Stacie Hiramoto stated REMHDCO has limited resources and feels that the Commission is important. REMHDCO respects and wants the Commission to be powerful. That is why the speaker attends Commission meetings.

Dave Nufer, California Depression and Bipolar Support Alliance (DBSA), stated the strategic plan is broad and global right now and is at the identifying possible targets stage. The speaker suggested saying “no” a fair amount as the process gets further down the road in that there is not a lot of bandwidth in terms of the Commission’s time and resources and there are a lot of problems. The speaker suggested scoping down and saying “no” over the next couple of years on worthy objectives.

Dave Nufer suggested the goal to improve three to five outcomes in the state over the next 18 to 36 months.

Elizabeth Lou, Nile Sisters Development Initiative, San Diego, stated they have been working with the Commission for two to three years. The last time the speaker communicated with the Commission was about crises among the refugee community in San Diego. This is ongoing. The speaker stated Nile Sisters knows the issues but is struggling with the lack of resources to help with these issues in the community.

Commissioner Discussion

Commissioner Berrick stated having public comment heard this way was a mistake. It is not an efficient way to communicate. The issues brought up by the public today require a two-way dialogue. Also, this needs to be done together and not at the end. A different way needs to be found on how to do this.

Executive Director Ewing agreed with Commissioner Berrick and stated his intent was for stakeholders to pull chairs up to the table and make it one big conversation and not to use the podium.

Commissioner Anthony stated common courtesy is appropriate to thank individuals for speaking. She apologized for not acknowledging public comments. She stated she and her fellow Commissioners appreciate them.

Commissioner Bunch asked how the sentence “everybody who needs care gets care when and where they need it” translates. She asked how to get from hearing the story to getting services for individuals.

Executive Director Ewing stated staff is trying to leverage existing data to begin to identify challenges that often come as anecdotes. Staff wants to put the background material behind them so that it can be much more compelling. Anecdotes are personal and compelling but they are often inadequate to drive changes at the county or state level. Staff is trying to put that information together in terms of what is currently on the website – dollars, programming, and outcomes – and empower the community to talk with their boards of supervisors about the challenges they see in their communities and that current programs are not working effectively. The idea is that that would then enhance the utility of the community-planning process.

Executive Director Ewing stated, on top of that, as the Commission identifies priorities that it is concerned about, it has the ability to leverage funds to help solve them. Staff is trying to align resources around defining challenges or setting an agenda and then implementing that agenda

with the array of tools that are already available and potential tools that can be developed specific to a particular issue. The intent is to focus the Commission on different topics over time that align with the agreed-upon priorities. This is about seeking clarity, prioritizing, and ensuring the effectiveness of the work of the Commission, which is the results-based accountability piece, and how to know if the Commission is being effective.

Commissioner Anthony asked what happens when staff gets a call from an individual who states their county is not listening to them about their input into the county plan.

Executive Director Ewing stated the law instructs the Commission to refer issues to the DHCS because the DHCS has performance contracts with the counties and has an oversight role, but staff tries to help by calling counties and providers and doing everything and anything it can, which is often inadequate. There is not a government response at the state level for many of the challenges raised.

Commissioner Alvarez stated she appreciated that staff goes above and beyond in trying to be responsive to community need and fill gaps. She suggested institutionalizing these processes so that the Commission as an oversight body has an opportunity to follow through on those responsibilities, and so Commissioners do this work as part of their responsibilities.

Executive Director Ewing stated that is what is trying to be done through the strategic planning process – so the Commissioners can assert their priorities that have the value of specific deliverables so they would know what staff is doing and the impact that it has.

Commissioner Alvarez stated the need to identify gaps and barriers that hinder the Commission from conducting the oversight it should be conducting and to think strategically about what a policy agenda looks like. When the Commission does not just react to legislation but suggests ideas to the Legislature that will make the Commission stronger at what it does.

Executive Director Ewing stated the transparency tool is doing that. It can be strengthened and ways to take on complaints could be considered.

Ms. Brutschy thanked everyone for their comments and asked Commissioners to let her know if they have any additional comments. She stated there is power in being explicit about what individuals can hold the Commission accountable for and what the Commission's roles are. Applied Survey Research is seeking an explicitness that is shared by every Commissioner and stakeholder.

Executive Director Ewing stated the next step is to work with Vice Chair Ashbeck to begin to draft the strategic plan, work on the rules of procedure, and provide opportunity to stakeholders to digest it.

GENERAL PUBLIC COMMENT

Tiffany Carter stated the need to ensure that the environment being created is welcoming to those individuals whose voices have so much meaning at the table. The speaker stated the last agenda item was difficult to comprehend and individuals who would love to be here and have meaningful input would struggle with it as well.

Tiffany Carter stated ACCESS California will be hosting its Empowerment Workshop in Long Beach on May 22nd and its MHSA Leadership Workshop at LEDMH on May 24th. The workshops are free for anyone to attend.

Rory O'Brien invited the Commission to the California LGBTQ Health and Human Services convening in Sacramento on May 28th and 29th. Community members, activists, and advocates

from across California will come together with the MHSOAC Commissioners and staff to spend time together at a reception from noon to 4:00 p.m. on May 28th.

Stacie Hiramoto thanked Commissioner Alvarez and others for caring about Nile Sisters Development Initiative. When the Commission first started, there were many members of the public who wanted the Commission to be an oversight body that would take individual complaints. A Committee met over several months to discuss the issue resolution process but it was a disappointment because the Commission decided to turn complaints over to the DHCS. The DHCS stated they would ask the county if the individual making the complaint went through the issue resolution process and, if the process was followed, they would not rule on anything. She asked the Commission to review this issue.

Poshi Walker thanked Commissioners who stayed to the end. The speaker clarified the previous comments about public comment. The speaker felt valued by Commissioner Anthony and others individually, but was referring to the process as a whole. The speaker stated, during the PEI regulation process, they would provide comment and the Commissioners would ask questions, and when Commissioners had more questions, they asked the speaker to return to the podium. That was a great use of public comment and was very valuable. The speaker suggested that there be a policy or something so it is clear what Commissioners should not do and what they can do to make the public comment period a valuable resource to the Commission.

Poshi Walker stated it was unfortunate that general public comment only happened at the end of the day because they were hoping to say something about public comment when all Commissioners were present.

Jane Adcock thanked Commissioners who stayed to the end. The speaker also thanked Commissioners for taking a risk and approving the Alameda County Innovation project, despite the questions Commissioners had and the concerns expressed during public comment. Innovation projects are meant to test things. This project is a test of small applications for specific targeted populations. The speaker stated appreciation that the Technology Suite is an awesome project, but it is very large and what will happen with it is unknown. The speaker stated maybe the smaller-scale applications will be more successful. They may not, but that is the whole underpinning of the Innovation component.

Commissioner Anthony thanked everyone who spoke and the issues they brought up. She stated she appreciated the frustration because from frustration there is growth. Everyone on the Commission has a passion for helping everyone and for solutions. Commissioners want to be effective and efficient in their solutions. She agreed with the things that staff has said and hoped that ways in the future can be looked into for determining priorities and, if it takes legislative action to identify priorities or change the priorities, that the Commission can consider that. Communities and members of the public have expressed frustration as a result of many of the systems in health care being changed. The Commission can look at opportunities to help those changes be community-driven instead of being based upon what is effective and efficient.

ADJOURN

There being no further business, the meeting was adjourned at 4:44 p.m.

AGENDA ITEM 2

Action

May 23, 2019 Commission Meeting

Orange County Innovation Plan

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

(A) **Behavioral Health System Transformation:
\$18,000,000**

In an effort to transform the behavioral health system, Orange County will work in collaboration with state and local agencies, public and private health plans, partnering agencies as well as their community to develop an integrated public/private behavioral health system to serve County residents (ages 18 and older), regardless of an individual's insurance coverage. Orange County states this project will involve intensive planning and will require the involvement of subject matter experts statewide and is intended to explore the feasibility of a system level change of this magnitude. It is important to note that Orange County states they will return to the Commission to seek funding for additional separate project proposals if the feasibility of this project proves to be successful in merging public and private funding to serve the residents of the County. The overarching goal of this project will ultimately include several interlinked components with the hopes of blending funding from private, public, and philanthropic sectors.

The Mental Health Services Act requires that an Innovation 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 Innovation 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 Orange County’s Innovation Project:

- Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency
- Clayton Chau, MD, Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health
- Courtney Ransom, JD, Family Member
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator

Enclosures (3): (1) Biographies for Orange County’s Innovation Presenters; (2) Behavioral Health System Transformation Staff Analysis; (3) Behavioral Health System Transformation 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:

<https://mhsoac.ca.gov/document/2019-04/orange-county-behavioral-health-system-transformation-innovation-project-may-23>

Proposed Motion: The Commission approves Orange County’s Innovation Project, as follows:

Name:	Behavioral Health System Transformation
Amount:	Up to \$18,000,000 in MHSA Innovation funds
Project Length:	3 years

Biographies for Orange County Presenters



Jeffrey A. Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency

Jeff Nagel is the Behavioral Health Director for the Orange County Health Care Agency. He brings to the role over 30 years of experience in the healthcare industry, varying from direct clinical services as a licensed psychologist to senior level management. Jeff obtained a Doctorate in Clinical Child/ School Psychology from the University of North Texas in 1989. He has held several positions with the Health Care Agency, building on the successes of previous positions, including Director of Operations for Behavioral Health Services, MHSA Coordinator, running Administrative Services and serving as the agency's Chief Compliance Officer for over ten years.

Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health

Clayton Chau is the Regional Executive Medical Director for the Mental Health Network, Providence St Joseph Health System, Southern California Region, where he joined in January 2017. Previously, he was the Senior Medical Director for Health Services at LA Care Health Plan and worked for the Orange County Health Care Agency Behavioral Health Services for 13 years. Clayton obtained his MD degree from the University of Minnesota and PhD in Clinical Psychology from Chelsea University. He completed his psychiatry residency at UCLA/San Fernando Valley followed by a fellowship with the National Institute of Mental Health in psychoneuroimmunology focusing on substance abuse and HIV. He has conducted international trainings in the areas of health care integration, health care system reform, cultural competency, veteran's health, trauma, homelessness and mental health policy. Clayton has recently been appointed by the 23rd US Secretary of Health and Human Services to the Interdepartmental Serious Mental Illness Coordinating Committee.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency

Sharon Ishikawa is the MHSA Coordinator for Orange County. She has 25 years of training and experience in clinical research design and data analysis, including as a Research Analyst for Community Services and Supports MHSA programs in Orange County. Sharon obtained her Ph.D. in Clinical Psychology from UCLA, completed research post-doctoral fellowships at the University of Southern California and the University of California Irvine, and served as an Assistant/Associate Project Scientist at the University of California Irvine.

Courtney Ransom, J.D., Family Member

Courtney Ransom lost her 13-year old son James to suicide in November 2016. Her experience as the mother of a child who had suffered from a traumatic brain injury and subsequent mental and behavioral issues inspired her family to do something to bring about change to how mental illness is viewed and how resources are accessed. With a strong Youth Board, The James Henry Ransom Foundation has been very effective at expressing the teen perspective and advocating its desire to bring an innovative local teen center to its community. The Foundation has also raised funds to support local mental health resources. Courtney has almost 20 years of experience in the health insurance industry, including experience in health care reform lobbying, compliance and advocacy. Courtney has a Bachelor of Arts degree in Economics from UC San Diego, and a Juris Doctor degree and Masters Degree in International Business from University of San Diego. She has served on the Board of Directors of the California Association of Dental Plans and National Charity League, Canyon Chapter.



STAFF ANALYSIS – ORANGE COUNTY

Innovation (INN) Project Name: Behavioral Health System Transformation
Total INN Funding Requested: \$18,000,000
Duration of Innovative Project: Three (3) Years

Review History:

Approved by the County Board of Supervisors: April 9, 2019
County submitted final INN Project: April 19, 2019
MHSOAC consideration of INN Project: May 23, 2019

Project Introduction:

Orange County is embarking on a large scale system transformation intended to meet the needs of all residents. The County will work in collaboration with state and local agencies, public and private health plans, and their community to develop an integrated public/private behavioral health system to serve County residents (ages 18 and older), regardless of an individual's insurance coverage.

Orange County states this project will involve intensive planning and will require the involvement of subject matter experts statewide and is intended to explore the feasibility of a system level change of this magnitude. It is important to note that Orange County states they will return to the Commission to seek funding for additional separate project proposals if the feasibility of this project proves to be successful in merging public and private funding to serve the residents of the County.

It is the ultimate goal of this project, when completed, that Orange County will have a "payer agnostic" behavioral health system where quality services can be provided to all residents within the County regardless of insurance type and given the moving parts that will need to be incorporated, this will be a monumental undertaking. This will ultimately include several interlinked components of funding braided from private, public, and philanthropic sectors.

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 the primary purpose of this project is to promote interagency and community collaboration related to Mental Health Services by introducing a new practice or approach to the overall mental health system.

The Need

Like most behavioral health systems, Orange County states certain communities continue to remain either un/underserved because specific providers may not be affiliated with an individual's insurance plan. As a result, variance in insurance coverage, current contracting practices and uneven payment rates have created a fragmented behavioral health system, with providers operating independently.

One of the biggest challenges the County hopes to address is the fragmented public and private behavioral health system. Too often, individuals who receive services through the public behavioral health system receive services that are focused on quantity-based (units of service) as opposed to quality-based services (based on outcomes of services). Another challenge that may contribute to the fragmented public/private behavioral health systems is the inability to access up-to-date directories that identify behavioral health resources and services that interweave both private and public health systems.

Although the County states their community planning process has identified the need to provide quality, person-centered care, **County may wish to provide more detail on why this is a need in their County or provide data to establish how many individuals do not receive proper care or needed services.**

The Response

In an effort to address the disjointed behavioral health system, the County has organized “Be Well Orange County”, which is comprised of faith-based groups, community based organizations, hospitals, stakeholders and local county agencies. The overarching vision of Be Well Orange County is to collaborate to transform the County’s behavioral health system to improve mental health and well-being without the hurdle of the bifurcated public and private health systems. Transforming both of these systems will require brainstorming, strategizing, collaborating, and partnering among various entities within the County. Part of the ability to work through some of these challenges has prompted the County to adopt Collective Impact, which the County states is a best practice model with a defined leadership structure.

The Collective Impact model is a commitment from a group from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration (Wikipedia, 2018). The premise behind the collective impact model, first articulated in a 2011 article found in *Stanford Social Innovation Review* by John Kania and Mark Kramer, is based on the notion that organizations addressing large-scale social problems have better coordinated efforts when a clearly defined goal has been set forth.

There are five criteria relating to the collective impact model:

1. Common agenda – all participating organizations must have a shared vision for social change
2. Shared measurement system – participating organizations must agree on how success will be measured and reported out
3. Mutually reinforcing activities – engagement of a diverse set of stakeholders that will assist in coordinating activities with a plan of action
4. Continuous communication – communication over long period of time shall remain between the key partners in an effort to build trust and encourage learning and adaptation
5. Backbone organization – this is ongoing support provided by independent staff to help the forward momentum of the shared vision

This innovation project will require Orange County to collaborate and partner with multiple subject matter experts, local and statewide agencies and organizations, local behavioral health organizations, private health plans, consumers, providers, family members and stakeholders with the purpose of discussing the feasibility and means of transforming the behavioral health care system.

Initial discussions will be focused around two areas: 1) discussing how federal regulatory requirements and respective funding sources can be integrated or streamlined in with private health care plans and; 2) identifying the greatest hurdles, and providing solutions for, accessing and engaging services within the current behavioral health system. Findings from these discussions will be utilized to help identify and provide guidance on how to overcome siloed public and private behavioral health care systems.

The results of these conversations will guide the next two parts of the project which the County states will happen simultaneously: **1) Aligning legal, fiscal and regulatory requirements to improve quality and access to services and; 2) Aligning local organizations to improve service navigation.**

1. Aligning legal, fiscal and regulatory requirements

The County will collaborate with public and private health plans, state and local agencies, and non-profit and philanthropic organizations in an attempt to coordinate a system of care that is payer-agnostic. Both federal and state funding streams will be identified along with rules and regulations that will frame discussions and strategies that may permit the braiding of funds across all sectors (private, public, non-profit, philanthropic). Additionally, the County and the collaborative partners will explore the feasibility of creating a *universal reimbursement rate* for providers so that consumers have better access to the provider of their choice regardless of insurance status, type, or the level of clinical need they are seeking. Methods to promote quality based treatment will be explored so that services provided are quality-focused (person-centered) as opposed to delivery of quantity-focused services. Developing a universal reimbursement rate will be a challenge and will require the input of the Department of Health Care Services, private health care plans and providers as well as the public behavioral health care system (**for complete list of activities relating to this element, please see pgs 7-8 of County plan**).

If discussions regarding the fiscal and regulatory requirements prove to be successful and feasible, the County will begin to develop and execute contracts to establish the agreed-upon provider reimbursement rate along with metrics associated with the delivery of quality focused services. Deliverables resulting from discussions will also include exploring the feasibility of a universal reimbursement rate, hosting planning meetings to identify community values and identifying service deliveries based on community-defined standards as opposed to quantity-focused services.

Additionally, it is important to note that the County indicates that if the above items prove to be successful, Orange County will return to the Commission to seek funding of future separate innovation project proposals to explore whether the newly identified quality based treatment metrics are resulting in quality improvement and whether all providers (public, private, and non-profit) can network together and agree upon a set of standards regarding the needs of unserved and underserved communities.

Given the complex infrastructure of the federal regulations that govern health care reimbursement, **the County may wish to discuss what they hope to learn from conversations with Department of Health Care Services and the likelihood that the parameters surrounding these funding sources may be changed.**

2. Aligning local organizations

Orange County states provider resources are largely out of date and are not complete in terms of available resources. For this component of the project, the County will collaborate with local agencies and organizations to consolidate all providers, both public

and private, into one electronic resource directory with the ability to allow providers direct access to update their information in real time so that information is always up-to-date. External contractors will build this digital resource directory and will perform testing to ensure directory is easy to navigate and locate needed resources. The County states this component will be implemented in various phases within this three year project due to the restructuring and collaborating that will guide this component. **For complete list of activities relating to this element, please see pgs 9-10 of County plan).**

If the digital resource directory is developed successfully, the *County indicates they will return to the Commission to seek funding of a future separate innovation project proposal to integrate a peer support model to assist in helping consumers and family members navigate behavioral health services across all sectors (private, public, and non-profit).*

In previous conversations with Commission staff, management, and County staff, the discussion of future separate innovation proposals were discussed in technical assistance calls and it was suggested to the County to highlight and provide clear, distinct learning objectives for each of the future separate project plans so that each project could be considered as a stand-alone innovation project.

The Community Planning Process

Orange County held their 30-day public comment period beginning February 15, 2019 through March 17, 2019. The County's local Mental Health Board held a public hearing on March 27, 2019 and received Board of Supervisor approval on April 9, 2019. This project was also presented to the MHSA Steering Committee on January 28, 2019 and received overwhelming support along with letters of support from community and statewide stakeholders (**see Appendix D of County plan for letters of support; also to be included in handouts**).

The Commission shared this Innovation Project with stakeholders beginning February 26, 2019 while the County was in their public comment period. Although the County states that no public comments were received at the County, Commission staff did receive a letter of support from the Steinberg Institute (included in handouts).

The County states that consistent community feedback and planning efforts dating back to 2016 have highlighted the need to focus County efforts on providing quality person-centered care for all communities within the County, to include some populations that have traditionally remained un- and underserved. Be Well Orange County (Be Well OC) was created in 2016 and is comprised of various public and private entities to address the challenges of the behavioral health system with the overarching vision of providing optimal care and well-being regardless of a person's ability to pay for services (**see Appendix B of County plan for Be Well OC stakeholders**).

The County has received cooperation and the support of numerous entities willing to support, engage and collaborate with the County on this innovation project including but not limited to their Board of Supervisors, local community organizations, community health plans as well as private health plans which supports the utilization of the Collective

Impact Model (see **Appendix B for complete list of members of Be Well Orange County**). This project will require extensive collaboration and coordination among many community organizations and county/state agencies to discuss approaches on best methods to intertwine the public and private behavioral health system in order to provide quality service to all residents within the County, regardless of whether an individual has public, private, or no insurance at all.

Per the direction of the Board of Supervisors, Orange County hosted seven (7) community engagement meetings throughout various parts of the County between July 31, 2018 and August 27, 2018 (see **Appendix C of the County plan for list of community planning meetings**) to assess the needs and gaps identified by stakeholders in the community. These meetings revealed needs and priorities that align with this project with the ultimate goal of transforming the behavioral health system to become payer agnostic along with its entailed components, which still have to be developed, depending on the success and learnings of this initial project.

The County indicates stakeholders have been and will continue to be extensively involved in all phases of the innovation project.

As part of MHSa General Standards, Orange County states this innovation project will depend heavily upon community collaboration and subject matter experts to discuss the feasibility of a system-wide change to the behavioral health system. Community planning activities will be culturally competent and responsive and will be client and family driven with an emphasis on wellness, recovery and resilience.

Learning Objectives and Evaluation

Orange County seeks to implement a transformational project which, through its use of Collective Impact, will promote interagency and community collaboration to improve the manner in which behavioral health care services are provided to its residents. Because this project is system-level, no direct services will be provided initially, however, the transformative project may create opportunities for future innovative projects.

While the evaluation will be further developed and completed during the initial phase of the project by a contracted evaluator, the County has provided components that will be utilized. Specifically, the County has proposed conducting a formative evaluation that will allow the County to identify the contributors to the effectiveness of the implementation during multiple phases of the project. While a formative evaluation is appropriate, and will result in important recommendations that will inform further implementation of the project, **the County may wish to discuss benchmarks that will need to be met to determine if (1) the evaluation is feasible, and (2) whether the project has met the necessary objectives to move to full implementation.**

To guide their project, Orange County has identified both inter-agency and community learning objectives. Inter-agency objectives revolve around the extent to which the project leads to the development of a model that can blend public and private funding

streams, and improve compliance, reporting and regulatory requirements among participating providers. Community learning objectives are centered on the extent to which community members feel their values are considered into the development of the performance metrics and standards that are utilized to determine the program's effectiveness and relevancy. In addition to these overall objectives, the County seeks to determine which collaborative meeting formats are effective in furthering the development of the project (**see pgs. 11-12 of County plan**). Additionally, post-implementation, the County has identified a number of key performance indicators that will be utilized to determine whether the project has been a success. These indicators revolve around a reduction in stigma, prevention and early intervention, as well as closing treatment gaps and improving access to services (**see Appendix A of County plan**).

To gather the data necessary for evaluation, the County plans to utilize focus groups, interviews, observational studies, as well as survey instruments. Data will be collected during inter-agency and inter-departmental meetings and workgroups.

At the conclusion of their project, the County will disseminate information to stakeholders through presentations to the Mental Health Board, MHSa Steering Committee, Be Well OC, as well as other local and state venues. Given the transformative potential of this project, the County may wish to brainstorm additional ways that lessons learned and findings from the project can be shared to promote statewide learning.

The Budget

This project will involve extensive planning and collaborations among many entities at the county, state, and private sector levels and will require the expertise and knowledge of subject matter experts. For this reason, a substantial portion of this budget is to bring collaboration and engagement for this plan.

The County anticipates this innovation planning project will be \$18,000,000 over a three (3) year duration, utilizing MHSa innovation funding. The cost of this project will cover expenditures relating to the project office, local and professional consulting, along with evaluation and administrative costs. The County has partitioned the total budget of this project into four main areas: (1) Project Office; (2) Consultations (Professional and Local Community); (3) Evaluation; and (4) Administrative. Each of the areas contain budgeted amounts for personnel (including benefits) and/or consultants.

The project office is budgeted to cost \$4,056,168 (23% of total budget), and will employ staff, peers, and management to support project activities and operations. Staff and peers will be responsible for the planning, coordinating and facilitation of project activities while a project manager will oversee project activities and daily operations. The County states the complexity of this project will require the project managers to be highly skilled and is expected to have appropriate degrees, credentials, and several years of experience to guide their efforts in this position. Additionally, individuals employed as Executive Leaders will possess many years of experience and will be considered senior leaders and will assist in ensuring this project aligns with the larger vision of Be Well OC. **County may wish to discuss how many staff will be needed for the project office.**

Costs for professional consultation are \$2,685,722 (15% of total budget). Orange County will require the collaboration and partnership of a broad range of external consultants for this project. The consultants will be compensated to address policies, strategies, legal advice and guidance, contract negotiations, document preparation, evaluation of regulatory requirements, and any peer and financial issues associated with the activities and deliverables of this project. Due to the complexity and unknown parameters of this project, it is presumed the County does not know how many professional consultants may be needed.

Local community consultation costs total \$7,324,846 (41% of total budget) and will cover costs associated with activities for engagement with stakeholders, consumers, family members, peers and providers. The County states peers, consumers, and family members will be hired to assist in the facilitation of these workgroups with the overarching goal of engaging populations who do not typically engage in community planning meetings. Costs will cover staff salary, benefits, meeting materials, advertisement and design of materials, translation services, and travel expenses incurred.

The County anticipates the evaluation costs to be \$1,497,717 (8% of total budget). Personnel needed for the evaluation will include a principal and co-principal investigator, evaluation subject matter experts, research assistants, and data scientists. Activities will include developing an evaluation plan and conducting evaluation activities (i.e. focus groups, surveys, stakeholder interviews). Associated costs will cover staff salary, benefits, and development of evaluation materials, computers and vital software, along with any travel expenses incurred.

Administrative costs for this project total \$2,435,258 (13% of total budget) and will cover indirect costs to monitor all contracts, project management, and project coordination for the multiple external consultants that will be relied upon to develop the various components of this project.

This project does not provide direct services, rather it is a planning project to test the feasibility of transformational change of the behavioral health system. As a result, there is no required plan for sustainability. In reference to Assembly Bill 114, Orange County will be utilizing funds subject to reversion from Fiscal Year 16/17.

Additional Regulatory Requirements

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

References

https://en.wikipedia.org/wiki/Collective_impact

https://en.wikipedia.org/wiki/Stanford_Social_Innovation_Review

Full project proposal can be accessed here:

<https://mhsoac.ca.gov/document/2019-04/orange-county-behavioral-health-system-transformation-innovation-project-may-23>

Behavioral Health System Transformation

Identifying the building blocks for a culturally responsive and inclusive system

Primary Problem

Orange County consumers, family members, and providers have identified several barriers to accessing needed behavioral health services. In particular, local community planning efforts from 2016 to present have repeatedly identified the following needs, gaps and challenges to providing person-centered and quality-driven care:



Cross-Sector Fragmentation

People can't get the right care at the right time due to lack of coordination across public and private behavioral health systems and services – and figuring out how to pay for out-of-network services (if they have insurance coverage).

Insurance Networks do not Support Person-Centered Access and Service Delivery

Un- and Underserved Populations (e.g., Veterans, LBGTQ, deaf and hard of hearing, monolingual communities, ethnic communities, etc.) can't access care due to inadequate provider networks determined by insurance status and type rather than their cultural needs and preferences.

Inadequate Access to and Knowledge of Existing Resources, Services, and Benefits and How to Navigate Them

Available resource directories have outdated and incomplete information and program listings. Additionally, people often don't understand eligibility and services covered by their insurance plans, and how to navigate both public and private behavioral health systems.

Available Care is Not Delivered Optimally

Families and other county stakeholders want a system based on quality and recovery-oriented outcomes, not quantity-based measures such as numbers served or units of service provided that are currently used in contract development and monitoring.

One of the most significant underlying barriers to addressing the above challenges involves the fragmented public and private behavioral health systems. As a result, people too often don't get the right care at the right time and face obstacles to knowing where to turn for care – such as identifying what is available to them – and figuring out how to pay for services that fall outside of their existing health plan, if they have one.

Project Goal: System Transformation

The goal identified by the community is to create a “payer agnostic” system where high-level, inter-agency fiscal and administrative coordination occurs so that local providers can serve all Orange County residents regardless of their insurance status, insurance type and/or level of clinical need (i.e., mild, moderate, severe). The development of a payer agnostic system will require system-transformation at two levels: aligning legal fiscal and regulatory requirements and aligning local organizations.

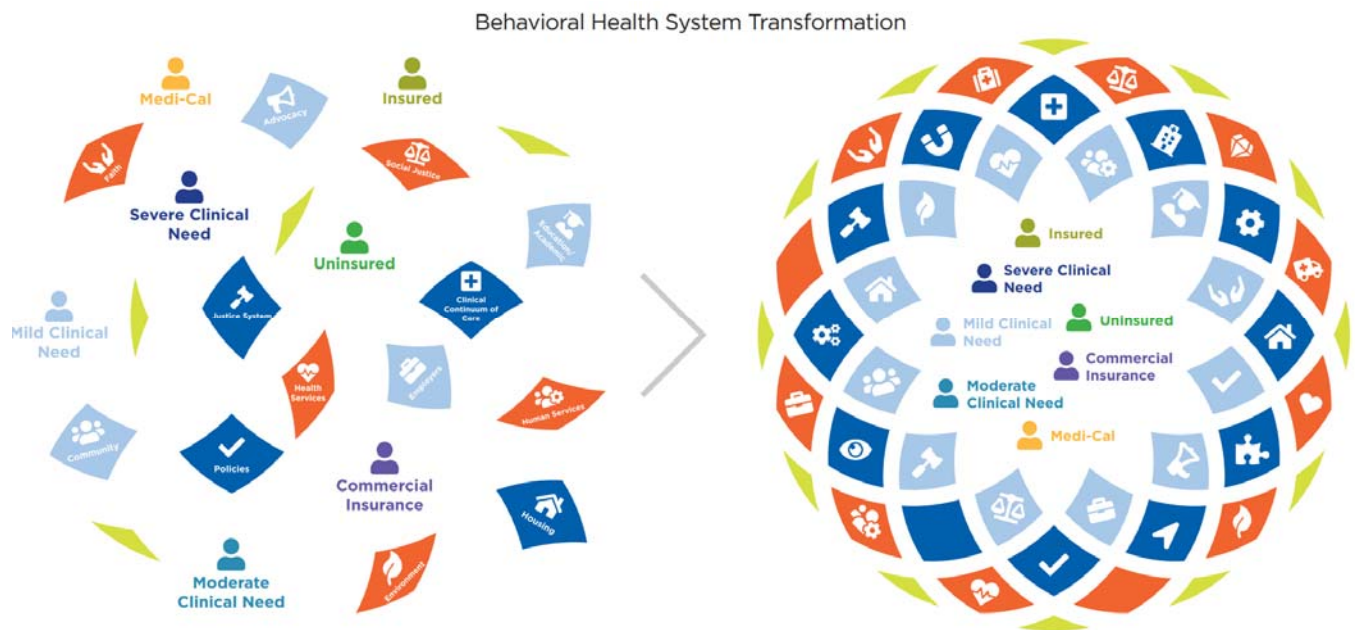
Aligning Legal, Fiscal and Regulatory Requirements to Improve Quality of and Access to Services: To address system-level barriers, Orange County will work with State and local agencies, public and private health plans, and philanthropic and non-profit organizations to create a coordinated system of care that bridges these sectors and improves quality of and access to services. Key deliverables include:



- Develop and execute initial procurement and contracts designed to braid funds and include community-defined values and performance-based metrics (in addition to regulatory requirements)
- Provide technical assistance for local providers, as needed, to prepare them for new contracting and performance standards

Aligning Local Organizations to Improve Service Navigation: Orange County will partner with local agencies and organizations to consolidate and integrate disparate directories into a single source. The key deliverable will be to deploy the digital resource directory and social determinants survey. Deployment will begin with a small-scale pilot and gradually expand in scope through later phases until it is available to all Orange County residents.

Fundamentally, what distinguishes this proposal from other efforts in California and across the nation is the goal of creating a payer agnostic public and private behavioral health system that is responsive, coordinated, and accessible to all Orange County residents.



Community Planning Process

Since 2016, Orange County stakeholders (i.e., consumers, family members, providers) have consistently identified the need to increase access to services, increase role/involvement of peers, improve system navigation, and leverage technology and partnerships with accountability. The premise of this proposal in identifying how to create a payer agnostic, culturally responsive behavioral health system is a direct response to the core needs and gaps identified by local stakeholders. Throughout the planning process, stakeholders have been providing guidance at every step, shaping the approach to this proposal. On January 28, 2019, the Behavioral Health System Transformation proposal was presented to the MHSA Steering Committee and received unanimous support. The project description was posted for 30-day public comment on February 15, 2019, and no public comments received, likely a result of the robust community involvement and feedback provided throughout the various planning meetings. On March 17, 2019, the project was presented at a Public Hearing held by the Mental Health Board and received unanimous support. The project proposal was approved by the Board of Supervisors on April 9, 2019. In addition to the unanimous approval received at these meetings, the Behavioral Health System Transformation project has garnered several letters of support from various local

community and statewide stakeholders, included with the proposal: California Pan-Ethnic Health Network (CPEHN); The Steinberg Institute; CalOptima; Beacon Health Options; Kaiser Permanente Orange County; and Blue Shield of California.

Part of Larger Community Effort

In 2016, a coalition of faith-based groups, hospitals, community-based mental health organizations, County agencies and other stakeholders, convened and formed what is now known as Be Well Orange County (OC). With acceptance that the behavioral health sector alone cannot solve all of the challenges of this complex and pervasive health challenge, Be Well OC brings together a robust, community-based, cross-sector strategy to transform systems and improve mental health and well-being. Be Well OC's vision is to establish a communitywide, coordinated ecosystem of optimal behavioral health care, supports and services.

Be Well OC represents all of Orange County — public, private, academic and faith — and leverages the community's diverse yet complementary assets and expertise. Be Well OC is harnessing a best practice model known as Collective Impact, with a clearly defined leadership structure. Collective Impact is an innovative and powerful model for transforming systems and solving complex problems and recognizes that these problems cannot be addressed by a single system or organization. Instead, leaders, representing the many sectors of a community, collaborate and strategically organize relevant stakeholders to accomplish a population-wide outcome.

As part of the collective impact sought through Be Well OC, Orange County proposes to promote extensive interagency collaboration across multiple sectors in an effort to restructure the manner in which behavioral health care is provided to residents.

What the Community Hopes to Learn

Inter-Agency Learning Objectives

- To what extent can Orange County develop a model that braids public/private funds to create a behavioral health system that serves all residents, regardless of payer source and level of clinical need?
 - At the conclusion of the project, what, if any, significant gaps or barriers remain in effectively creating an ideal payer agnostic system and what are potential solutions?
- To what extent can Orange County streamline and improve compliance, reporting and regulatory requirements in order to support providers participating in the payer agnostic system?
 - Compared to current business practices, do practices developed by this project streamline and/or simplify processes (e.g., reduced paperwork, efficiency achieved through a switch to automated and/or shared data systems, improved satisfaction with developed forms, etc.)?
- Based on survey and/or observational data, are specific meeting formats, group sizes, etc. more conducive to discussion, trouble-shooting, etc. among participating agencies?

Community Learning Objectives

- What did community members identify as their key values when considering a behavioral health program's effectiveness and worth?
- How were these community values translated into performance metrics and program standards and, based on survey and/or focus group data, to what extent were community members satisfied with these operationalizations?
- Compared to existing community meeting attendance, was Orange County able to increase engagement by stakeholders from the underserved and unserved communities through new outreach strategies?

- Based on survey and/or observational data, were specific meeting formats, sizes, etc. more conducive to discussion, trouble-shooting, etc. among participating agencies?
- Did satisfaction with and/or participation rates in specific meeting formats, group sizes, etc. differ across target populations?

Budget

The budget for this project is categorized into four main areas that will support the various proposed activities.

- **Project Office:** To support the effort, a dynamic project office will be established with staff and peers who will support all project activities and ensure efforts align with other related community endeavors.
- **Professional Consultation:** In recognition of the extensive need for specialized knowledge and expertise, as well as capacity, Orange County is proposing to engage a broad range of external consultants to support the complexity of this project.
- **Local Community Consultation:** The budget for local community consultation includes specific costs for activities associated with engaging local stakeholders, including consumers, family members, peers, and providers. Due to the value of their lived experience and their unique perspectives of the behavioral health system, consumers, family members and peers will be hired to assist with facilitating workgroups.
- **Evaluation:** The budget for evaluation includes costs for all levels of evaluation and research staffing.
- **Administrative:** Administrative expenses are included in the budget, which includes indirect costs for the County and fiscal intermediary(ies).

Budget Summary

Category	FY 18-19	FY 19-20	FY 20-21	FY 21-22	Total
Project Office	\$49,875	\$1,521,520	\$1,437,231	\$1,047,541	\$4,056,168
Professional Consultation		\$1,475,530	\$694,950	\$515,242	\$2,685,722
Local Community Consultation		\$4,145,062	\$2,112,119	\$1,067,665	\$7,324,846
Evaluation	\$9,975	\$579,630	\$542,224	\$365,888	\$1,497,717
Administrative		\$1,258,899	\$735,380	\$440,979	\$2,435,258
Total	\$59,850	\$8,980,641	\$5,521,905	\$3,437,315	\$17,999,710

AGENDA ITEM 3

Action

May 23, 2019 Commission Meeting

Ventura County Innovation Plan

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

(A) **Conocimiento: Addressing ACEs through Core Competencies: \$1,047,100**

- Ventura County plans to increase resilience and community building activities, which are known to benefit youth with adverse childhood experiences (ACEs), by using a community driven practice called Conocimiento, which combines resiliency building and community involvement in two local community centers. These activities will include community meals, skill building activities, and will be rotated between the two community centers with transportation being provided to facilitate participation by youth. There will be a speaker/presenter at each of the meals who will be part of the program (chosen by youth) and who will focus their presentations on topics that increase executive functioning, one of the practices to help ACE-impacted youth to increase protective factors associated with the risk of ACEs.

The Mental Health Services Act requires that an Innovation 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 Innovation 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 Ventura County's Innovation Project:

- Kiran Sahota, MA, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health
- Hilary Carson, MSW, MHSA Administrator, Innovations, Ventura County Behavioral Health

Enclosures (2): (1) Biographies for Ventura County's Innovation Presenters; (2) Conocimiento 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:

<https://mhsoac.ca.gov/document/2019-04/ventura-county-conocimiento-addressing-aces-through-core-competencies-innovation>

Proposed Motion: The Commission approves Ventura County's Innovation Project, as follows:

Name:	Conocimiento: Addressing ACEs through Core Competencies
Amount:	Up to \$1,047,100 in MHSA Innovation funds
Project Length:	4 years



Kiran Sahota, MA

Mental Health Services Act Senior Behavioral Health Manager

Ventura County Behavioral Health

Kiran has managed all MHSOAC activities in Ventura County since 2015. She has worked in Ventura County Social Services for over 20 years. She has experience in the child welfare system, law enforcement, and community collaboration. Her advanced education is in Clinical and Community Psychology.

Hilary Carson, MSW

MHSOAC Administrator, Innovations

Ventura County Behavioral Health

Hilary received her MSW from NYU in Policy and Programs; she has a background in working with Community-Based Organizations specializing in parents and families involved in the criminal justice system. She joined Ventura County Behavioral Health in June 2016.



STAFF ANALYSIS – VENTURA COUNTY

Innovation (INN) Project Name:	Conocimiento Addressing ACEs through Core Competencies
Total INN Funding Requested:	\$1,047,100
Duration of Innovative Project:	4 Years

Review History:

Approved by the County Board of Supervisors:	April 9, 2019
County submitted INN Project:	April 12, 2019
MHSOAC consideration of INN Project:	May 23, 2019

Project Introduction:

Ventura County plans to increase resilience and community building activities, which are known to benefit youth with adverse childhood experiences (ACEs), by using a community driven practice called Conocimiento, which combines resiliency building and community involvement in two local community centers. These activities will include community meals, skill building activities, and will be rotated between the two community centers with transportation being provided to facilitate participation by youth. There will be a speaker/presenter at each of the meals who will be part of the program (chosen by youth) and who will focus their presentations on topics that increase executive functioning, one of the practices to help ACE-impacted youth to increase protective factors associated with the risk of ACEs (page 8).

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 and community collaboration related to mental health services or support or outcomes.

The Need

The County reports that the residents of Santa Clara Valley, comprising three communities Fillmore, Piru and Santa Paula are separated from the rest of the County, economically, socially and educationally. These communities have a history of gang rivalry and increased instances of juvenile justice involvement. The communities are also culturally isolated with over 95% of the population being Hispanic or Latinx, have high levels of poverty and limited transportation options. This huge disparity between the valley communities and the rest of the County is further exacerbated by very few positive environments or community support for youth and lingering gang violence and school rivalries. Because there are so few ways to mitigate the effects of these childhood stressors and ACEs through after school programs (there is both a significant drop out rate as well as a suspension rate in the local schools), sports (many students are disqualified due to poor grades), and counseling services, these towns have individually started two programs to build positive communities for youth; Ignite and One Step a la Vez. **The County may wish to describe outcomes from these programs.**

The County reports they are trying to reach these community youth through traditional mental health services but report they are meeting resistance on the part of youth as the result of the political climate, the continuance of rivalries (some youth have never been to the other town), stigma and fear. They have begun to build community centers and there are some very small grassroots organizations that are supporting youth. However, these organizations are small, have few staff, and are difficult to sustain. Transportation is also a significant barrier in this rural area. **Further, the County may wish to identify the number of youth it thinks currently qualify for mental health services who are not participating in them and the number of students impacted by ACEs either in these communities.**

The Response

The County is testing the efficacy of a community gathering and a dinner rotated between two youth centers to see if this intervention helps build resiliency in youth and help to develop better executive functioning as a means to build protective behaviors and reduce risk factors like ACEs. The weekly program will culminate with a summer event designed and planned by the youth through a consensus decision-making process.

The meal also serves as a bridge to develop community relationships between youth and families. To this end, the County is adding a family liaison to each of the youth centers. This person will provide support to the families of participants (families of youth participants will also be invited to the meals. Family liaisons will serve as cultural brokers and advocates and will offer in-home services such as system navigation, parent support meetings, skills development and emergency resources. The County's goal in including these family liaisons is to establish the routine of family dinners and a vehicle for participants to interact with other community members (including community leaders, elders, and professionals). The routine family meal has been associated with improved and stronger resilience, better grades, improved vocabularies (page 7-8) and core competencies in terms of decision making. **The County may wish to address if youth peers will be part of this process, either as community liaisons, as presenters, or as system navigators or any additional roles they anticipate peers could have in this project.**

The meal will also serve as a vehicle for presentations and small group discussions focused on fostering executive functioning (page 6) and include "trainings" such as decision making, mental health awareness, self-assessment and goal setting, and cultural identity. (See page 6 for a complete list of topic areas to be covered). The county estimates they will serve 200 youth over four years and that the population of participants will be predominantly Latinx. Referrals are anticipated from youth identified by County Probation and the County also reports it wants to focus on referrals from the LGBTQ community.

Research conducted by Commission staff found data from the Trauma Resource Institute that indicates the Community Resiliency Model (CRM), which includes a community process is particularly suited for this community, as identified by Ventura County:

CRM® has largely been used with individuals and communities, which have been marginalized either by economic challenges, ethnicity, and natural and human-made disasters. Applying CRM proactively with an entire community or neighborhood that is chronically stressed can alleviate the symptoms of chronic stress placing the community and its members in a better position to change their situation by increasing their resiliency. There is a substantial and growing evidence base for the efficacy of CRM® in reducing anxiety, depression, somatic symptoms and hostility indicators (State of California, Mental Health Act, CRM Innovation Project, 2013).

Throughout California Counties, community meals have been used primarily for cultural connectedness (Africentric Youth and Family Rites of Passage Program, Riverside), or nurturing family relationships as a resiliency tool (The Nurturing Families Program, Modoc). These programs and services are primarily funded under MHSA Community Services and Supports or Prevention and Early Intervention programs and these programs are not designed to test or record improvement in building resilience, executive functioning, and improving community involvement. No program currently in the Commission's programs and providers data base is designed for the population or purpose as Ventura's Conocimiento program.

The Community Planning Process (CPP)

The County reports it has modified its CPP process in 2016. It has established community forums held in three geographic areas where training on the MHSA values and the CPP process is discussed. Community members at those forums are then provided an opportunity to “brain storm” community needs and ideas and ultimately a community list of 52 ideas was developed.

The 52 ideas were vetted by the MHSA Planning Committees, comprised of behavioral health advisory members. The final list with the top five innovative ideas the committees selected is then presented to the full Behavioral Health Advisory Board for approval. The idea for the weekly community center meals came from the centers themselves. Participants from the One Step a la Vez submitted the original idea in 2017. A meeting was hosted by Ignite and 35 youth participated in the development of the plan. The feedback from the group was positive with transportation being the only problem they identified. This contingency has been covered in this Innovation proposal. Additionally, the County reports that local city council members are in support of the plan and intend to participate in community events.

This project was shared with the Commission stakeholders on February 27, 2019 and there were no letters of support or opposition received.

Learning Objectives and Evaluation

Ventura County seeks to implement a community driven practice called — Conocimiento—that will serve the primary purpose of promoting interagency and community collaboration related to Mental Health Services or supports or outcomes. Specifically, the program will focus on building resilience, executive functioning, and improving community involvement. Conocimiento will target individuals between the ages of 13-19 that are existing members of One Step a la Vez and Ignite, have been referred by Ventura County Probation, the Insights Program, or by local middle and high school administrators. The County seeks to serve 50 individuals annually for a total of 200 over the course of the project.

To guide the evaluation of their project, Ventura County has identified several primary and secondary goals. Primary goals are centered on the degree to which the program has an effect on youth’s resilience, supportive adult relationships, youth competencies, as well as parenting self-efficacy (**see pg. 10 of County plan**). Additionally, the County has identified several expected outcomes from the project, including those relative to improved individual well-being, improved economic wellbeing and stability, as well as improved parenting (**see logic model on pg. 24 of County plan**).

ACEs information, self-assessment surveys and annual focus groups will be utilized to gather data on participant demographics, attendance frequency, level of participation, as well as information relative to outcomes. ACEs information will be gathered at intake as well as at the completion of the program. Surveys will be administered pre- intervention

(baseline) as well as twice a year during the duration of the project. Specifically, survey instruments may incorporate a number of different scales, including:

- Resilience Scale 14 (RS-14)
- Self-Control scale of social emotional and character development scale (SECDS-4)
- Community Engagement and Connections Survey-Connection to Community Subscale (CEC-5)
- Revised Implicit Theories of Intelligence (RITI-3)
- Multicultural Inventory of Parenting Efficacy, among others (**see pgs. 11-13 of County plan**)

Conocimiento was developed in response to a number of community and individual factors, with the intention of uniting two communities. With this in mind, the County may wish to explore the effect that the project has on not only bridging the two communities, but also its effect on reducing other risk factors associated with high ACEs scores (i.e. poor academic performance, suspension rates, delinquency) As a method of disseminating lessons learned, The County will develop a documentary video on the program process that will be shared with partnering high schools, city councils, the Behavioral Health Advisory Board, as well as the public at the conclusion of the project.

The Budget

The County is seeking authorization to spend \$1,047,100 for this Innovation over a 4 year period. Personnel costs in the amount of \$492,542 represent 47% of the total budget. These salary costs will support County and youth center staff who will be responsible for overall supervision, managing the weekly dinners, arranging speakers and include the parent liaisons for communication between project staff and team members' parents.

Operating costs in the amount of \$246,789 represent 23.5% of the total budget. These costs include program materials, guest speakers, meals, youth incentives, field trips, support services, events and video production.

Non-recurring costs in the amount of \$15,500 represent less than 1% of the budget and cover the costs of equipment such as tables, chairs, computers, printers, cooking equipment for each of the centers.

Indirect costs in the amount of \$67,165 represent 6% of the total budget and will cover overhead for the contracting cost. Transportation costs in the amount of \$88,526 represent 8% of the total budget and will be used to facilitate attendance at the family dinners

The county may wish to clarify what part of the total \$910,521 designated as consultant contractor costs is allocated to the evaluation.

Additional Regulatory Requirements

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

References

<http://buncombeaces.org/build-resilience-2/>

<https://centerforyouthwellness.org/health-impacts>

<https://www.census.gov/quickfacts/fact/table/venturacountycalifornia,US/PST045218>

<https://www.traumaresourceinstitute.com/new-page-2>

Full project proposal can be accessed here:

<https://mhsoac.ca.gov/document/2019-04/ventura-county-conocimiento-addressing-aces-through-core-competencies-innovation>

AGENDA ITEM 4

Action

May 23, 2019 Commission Meeting

Los Angeles County Innovation Plan

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

(A) **The Trieste Project: True Recovery Innovation Embraces Systems That Empower: \$116,750,000**

Los Angeles County proposes to test a pilot in the Hollywood region of the county that has the potential to dramatically transform the landscape of the current mental health system. The County is requesting Innovation funds to temporarily replace the entire existing public mental health funding system to test a new payment and documentation system to see whether it will improve the effectiveness and satisfaction of mental health services resulting in improved outcomes without increasing cost. If successful, the County plans to expand the model across county services and is hopeful that they can demonstrate to the state of California and the federal government that the Medicaid financing and accountability system should be changed.

The Mental Health Services Act (MHSA) requires that an Innovation 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 Innovation 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 Los Angeles County’s Innovation Project:

- Jonathan Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County
- Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County
- Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center
- David Pilon, Ph.D., C.P.R.P., Mental Health Consultant

Enclosures (3): (1) Biographies for Los Angeles County’s Innovation Presenters; (2) Trieste Staff Analysis; (3) Trieste 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:

<https://mhsoac.ca.gov/document/2019-05/los-angeles-county-trieste-innovation-project-may-23-2019>

Proposed Motion: The Commission approves Los Angeles County’s Innovation Project, as follows:

Name:	Trieste
Amount:	Up to \$116,750,000 in MHSA Innovation Funds
Project Length:	5 years



Biographies for Los Angeles County Presenters

Jonathan Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County

Dr. Jonathan Sherin is a longtime wellbeing advocate who has worked tirelessly throughout his career on behalf of vulnerable populations in public and private sectors. In his current role as Director of the Los Angeles County Department of Mental Health (LACDMH), he oversees the largest public mental health system in the United States with an annual budget approaching \$3 billion. Prior to joining LACDMH, Dr. Sherin served for over a decade at the Department of Veterans Affairs (VA) where he held a variety of clinical, teaching, research, and administrative positions as well as academic appointments. In his last such post, Dr. Sherin directed mental health for the Miami VA Healthcare System and served as vice-chairman for the Department of Psychiatry and Behavioral Sciences at the University of Miami.

In addition to his leadership in the health and human services sector, Dr. Sherin has a portfolio of scientific accomplishments that include seminal sleep studies featured in *Science* magazine as well as a conceptual model of the psychotic process for which he received the prestigious Kempf Award from the American Psychiatric Association. Dr. Sherin completed his undergraduate study at Brown University, his graduate work at the University of Chicago and Harvard Medical School, and his residency in psychiatry at UCLA. He is currently a volunteer clinical professor at both UCLA and USC.

Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County

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



Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental health Center

Mr. Romero received his Bachelor of Arts degree in Psychology and his Master of Social Welfare degree, with a concentration on Community Mental Health in both from the University of California at Berkeley. He also earned a Master's Degree in Public Administration from the Tseng College at California State University Northridge. Jesús has 20 years of county service as a professional social worker. He is currently the Program Manager at Hollywood Mental Health Center. Jesús is committed to working with underserved communities in Los Angeles County and is an advocate for integrated, community based services.

David Pilon, Ph.D., C.P.R.P., Mental Health Consultant

David Pilon received his doctorate in Social Psychology from Harvard University in 1981. He is a licensed psychologist and served as the Chief Executive Officer and President for Mental Health America of Los Angeles from October 2009 until his retirement in November 2017. In 1989, he was the lead writer for the grant writing team that produced the successful bid to design and implement the Village Integrated Service Agency in Long Beach, California. He has consulted in the design and transformation of mental health programs and systems throughout the United States, New Zealand and Japan. He is a past president for the California Association of Social Rehabilitation Agencies and served on the Evaluation Committee of the Mental Health Services Oversight and Advisory Commission. Dr. Pilon has presented numerous workshops on ethics and leadership issues in psychosocial rehabilitation as well as on the development of outcome measures for social rehabilitation programs.

From 1999 through 2007, he served as the lead evaluator coordinating the collection and analysis of data documenting the effectiveness of the Integrated Services for the Homeless (AB34) program serving nearly 5000 people who are mentally ill and had been incarcerated and/or homeless. He is the co-creator of the Milestones of Recovery Scale and has served on the Performance Measurement Advisory Committee (PMAC) for the California State Department of Mental Health. He is the Principal Writer for the California Institute of Behavioral Health's Full Service Partnership Performance Measurement Toolkit. In 2004 he received Psychiatric Rehabilitation Association's (PRA) Armin Loeb Award for outstanding research in the field of psychiatric rehabilitation.



STAFF ANALYSIS – LOS ANGELES COUNTY

Innovative (INN) Project Name:	The TRIESTE Project: True Recovery Innovation Embraces Systems That Empower
Extension Funding Requested for Project:	\$116,750,000
Duration of Project:	5 years
Review History:	
Approved by the Board of Supervisors:	After Commission Approval
County Submitted INN Project:	April 29, 2019
Commission Consideration of INN Project:	May 23, 2019

Project Introduction:

Los Angeles County proposes to test a pilot in the Hollywood region of the county that has the potential to dramatically transform the landscape of the current mental health system. The County is requesting innovation funds to temporarily replace the entire existing public mental health funding system to test a new payment and documentation system to see whether it will improve the effectiveness and satisfaction of mental health services resulting in improved outcomes without increasing cost. If successful, the County plans to expand the model across county services and is hopeful that they can demonstrate to the state of California and the federal government that the Medicaid financing and accountability system should be changed.

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

Los Angeles County states that the current mental health system in Los Angeles and beyond has been unable to reach a core goal of the recovery model to help people living with severe mental illness achieve true community inclusion. The County cites the increasing level of unhoused people living with mental illness as an outcome of the current system not working.

The County goes on to specifically identify that the way our mental health system is financed, regulated and reported on are the barriers preventing the goals of the Mental Health Services Act (MHSA) and recovery model (**see Appendix 1 for details of the recovery-oriented service categories**) from being realized.

Los Angeles County argues that the “failure to deliver on the promise of the recovery model is to be found in the way that we finance mental health care in the United States.” The County cites that the U.S. mental healthcare system is driven by two closely related factors:

- (1) compliance with the Medicaid-based fee-for-service payment system and its copious associated regulatory processes that are intended to ensure accountability, and
- (2) an over-emphasis on the treatment and mitigation of the symptoms of the illness rather than on the well-being of people served and their re-integration into the community at large.

The County contends that these two factors prevent the treatment of the whole person because the focus is on the illness and not on ensuring that people with mental illnesses have appropriate housing, social connection, belonging and purpose in their lives. In addition, staff spend 25% of their time on documentation instead of on providing services.

The necessity of this project, as stated by the County, is substantiated by a 2018 Rand report examining program reach and outcomes in Los Angeles County. Researchers noted, “[n]ew measures are needed to understand how clients are doing with respect to whether they have ‘somewhere to live, someone to love, and something to do’ and other indicators of recovery from serious mental illness [...] Because many data-collection procedures are state-mandated, advocacy may be needed at the state level to adjust data-collection requirements.”

The Response

To demonstrate that a recovery-oriented model can be successful in a bureaucracy, this pilot project proposes to implement five innovations to improve individual and system outcomes and satisfaction in the mental health system without increasing costs of services.

The five proposed innovations are:

1. **A Recovery-Informed Reimbursement System-** replaces the current “bill by the minute and more services equals more payment model” with a multi-tiered reimbursement system based on outcomes of services and the level of need of the person being served.
2. **Recovery-Informed Documentation and Process-Monitoring(see pgs. 19-22 for complete details)-** replaces the current illness focused, service classification system with whole-person focused monitoring system designed to support members to achieve the following goals:
 - a. A safe and healthy home in the community (HOME & HEALTH),
 - b. Acquiring and maintaining familial, social and intimate relationships (LOVE AND BELONGING), and
 - c. Acquiring and maintaining meaningful roles in the larger community (PURPOSE).
3. **Recovery-Informed Performance Measurement (see pgs. 23-30 for complete details)-** replaces the current process monitoring with the Key Event Tracking System (already used to track outcomes for full service partnerships) allowing the County to judge the effectiveness of the pilot not by the quantity of services but by how effectively the pilot increased independent living, employment and reduced rates of incarceration and hospitalization in members served (**see the below evaluation section for more details**).
4. **Shifting to the Provision of “Well-Being-Focused” Services-** creates an assigned “health home” for each member appropriate to their level of care that is focused on addressing both physical and mental healthcare where psychosocial services are the primary focus and clinical services move to a support role. Health homes may be a full service partnership, a wellness and peer run center or an outpatient clinic depending on level of care needed.
5. **Technology that supports payment, documentation and accountability reforms-** to support the changes initiated in the first three innovations, the County proposes to eliminate the “soul-killing” paperwork required by Medi-Cal billing by providing staff a HIPAA-compliant electronic health record that staff can record their interactions with members and related activities through a quick, voice enabled documentation protocol.

Los Angeles County developed these innovations after a group of staff and stakeholders visited Trieste, Italy to study the local mental health system (recognized as an exemplary system by World Health Organization for deinstitutionalization and community mental healthcare) (Boffey, 1984). The group learned that the jails were not overcrowded with inmates with mental illness, there were few homeless individuals with mental illness and involuntary hospitalizations were rare. Staff identified significant differences in how the two systems were financed, differences in reporting requirements and differences in how the two systems are regulated. Trieste staff provided a whole person, “whatever it takes” community approach to care and spent less time on documentation. Trieste staff also explained that the philosophy of their care is more important than specific services. The philosophy is based on a holistic approach of the individual, not the disorder; an ecological approach where the social group and network is emphasized with care offered by the larger community; and a legal approach with the emphasis on civil rights and inclusion.

With the Italian model as its inspiration, the County is requesting an approval to implement the five previously discussed innovations over a five year period with the first year of the project used to engage community stakeholders, secure all necessary regulatory waivers, establish evaluation contracts and protocols, and improve facilities for the new services. The County states that they anticipate the most significant challenge to implementation will be securing a waiver from the Department of Health Care Services (DHCS) that allows the use of non-Medi-Cal funds (Innovation funds) for Medi-Cal recipients and addressing any legal and regulatory issues that may arise from this practice. The County feels that there is a precedent for the approach proposed here in the current DHCS Whole Person Care waiver that provides for a per person per month payment system. **The Commission may wish to ask the County to discuss the timeline for securing a waiver from DHCS.**

Following the planning year, doors will open and services will begin July 1, 2020. Examples of reimagined services under the pilot, include: an outreach and engagement team (includes a peer advocate) housed at an extended hours drop-in center with team responsibilities of assessing member's level of need, referring to care and connecting to social/recreational activities. In addition, access to mental health staff after hours will be available 24/7 and access to alternatives to emergency rooms with 10 peer respite beds, 10 crisis beds, and 10 behavioral health urgent care beds. To reduce system fragmentation, a system concierge will serve as an ombudsman for members and other stakeholders and also track all transitions between urgent and non-urgent levels of care.

The concept informing this pilot is not new to California. In 1990 the California Legislature funded a program through Mental Health America to create a demonstration project with a “whatever it takes” approach to providing community mental healthcare (Ragins 2016). The County presents the outcomes of the Village project as an example of a successful single tiered payment model resulting in significant improvements in member satisfaction and community integration while incarceration and hospitalization rates decreased.

Comments

The proposal goes into detail about the importance of meaningful activities and employment in recovery, highlighting that accredited social cooperatives provided training and meaningful roles for service recipients and was a critical component in the Italian model. Employment was also an important outcome of the Village. Given this critical level of importance, the Commission may wish to ask Los Angeles County to not just consider this as a component of the model but make it an integral part of the services by including employment support positions in the budget.

While the County is correct in highlighting the positive outcomes and potential of the Village Model, the County may wish to discuss how they will overcome the significant homelessness numbers and account for the lack of housing provided in this proposal given that both the Village and the Italian model did not have to overcome the same inadequate housing options that are present in Hollywood.

The Community Program Planning (CPP) Process

The County is requesting planning dollars to use during the first year of the project in part to engage various stakeholders into the design of the new service system model including evaluation.

The initial community involvement for this proposal came from a group of individuals who visited the mental health system in Trieste, Italy. The involvement, dedication and the closeness of the local community members led the County to select the Hollywood region as an appropriate pilot area. Commission staff observed the closeness and dedication during an information session with various members of the Hollywood business community in April 2019.

The County explains that because the major innovations being proposed are payment, documentation, and accountability systems, significant involvement was solicited from the staff of the programs serving the proposed pilot region. Four listening sessions were held to hear directly from staff the issues that they believed were hindering them from offering optimal services to their clients and these comments were incorporated into the proposal. In addition, the County states that information about the proposed model was shared by the director and other executive leadership at various stakeholder engagements including a community forum.

During the 30 day public comment period, the County states that they received more than 40 comments (primarily positive). The County will also hold a countywide community forum on Monday, May 13, 2019 to further solicit input on the proposal. **The Commission may wish to ask the County to share any meaningful feedback (positive and negative) received from Community members.**

The County outlines further plans to ensure meaningful participation of stakeholders, including peers, throughout the planning, and implementation of the project.

This proposal was shared with Commission stakeholders on April 18 2019 and one comment in support of the project was received. An excerpt is provided here: “I think this comprehensive care approach with funding changes is long overdue. The village approach model is more encompassing to each person's unique needs in the community. Employment is critical to engagement and self- realization.” The full comment was sent to the County.

Learning Objectives and Evaluation

Los Angeles County seeks to implement a pilot project consisting of five separate components aimed at creating a recovery-informed system to improve individual and systematic outcomes, as well as consumer satisfaction. While this project will serve multiple purposes, it will increase the quality of mental health services as evidenced by multiple measured outcomes as outlined below.

The County will target individuals 18 years of age or older who (1) reside in the Hollywood area and meet the criteria for specialty mental health services, or (2) do not live within the Hollywood area, but received mental health or substance use services from a County

Department of Mental Health directly-operated contract provider between July 1, 2017 and June 30, 2019 (**see pgs. 41-42 of County plan**). The County states that the total population for the Hollywood region was 103,625 in 2016, however an exact estimate of individuals that will be served over the four-year project is yet to be determined.

In order to evaluate the effect of TRIESTE, results and outcomes will be compared to a region that is similar demographically, fiscally, and in population size as identified by a university-based evaluator. Survey instruments, the Key Event Tracking System (KETS) as well as the Milestones of Recovery Scale (MORS) will be used to gather the data necessary for evaluation. All evaluation methods and measures will be applied to the comparison region. To guide their project, the County has identified three main learning questions centered on determining (1) if the lives of individuals being served by the project are improved, (2) how outcomes fare between the TRIESTE group and the comparison population, and (3) how costs of providing services differ between the TRIESTE group and the comparison population.

Additionally, Los Angeles County has identified intended outcomes of the pilot project, as well as measures and indicators to meet these outcomes (**see pgs. 48-53 of County plan**), and include:

1. Improved quality of life
 - a. **Measures:** Love and belonging, purpose, social connectedness, and other self-report measures.
2. Reduction in adverse events
 - a. **Measures:** Emergency room utilization rates; hospitalization rates; and Incarceration rates.
3. Improved functional status
 - a. **Measures:** Managing medications; managing money; managing public transportation; managing community relations; and managing activities of daily living.
4. Improved member satisfaction with care
 - a. **Measures:** County will seek stakeholder input into the development of measures around satisfaction with care. Possible items center on whether the individual feels welcomed and respected by staff, satisfied with their role in making decisions about their care, as well as having the opportunity to involve their family or other support systems in their receipt of services.
5. Improved staff job satisfaction
 - a. **Measures:** County will seek stakeholder input into the development of measures around job satisfaction. Possible items will include the extent to which staff report feeling hopeful, engaged with the community, empowered, and report being part of the healing process.
6. Improved family and larger community satisfaction
 - a. **Measures:** County will seek stakeholder input into the development of family and community satisfaction measures. Possible items will include the extent to which family/community members report feeling welcomed

and respected by staff, satisfied and comfortable with their role in their family member's care, and having adequate opportunities to be involved in the provision of care of their family member.

7. Reductions in the overall cost of care
 - a. **Measures:** Costs of outpatient mental health services, physical healthcare, substance abuse prevention services, emergency room services, hospital services, and jail and prison services incurred will be compared between the pilot project population and the comparison population.

Los Angeles County has prepared an evaluation plan that will be further developed by a university-based evaluator. Additionally, the County will engage the larger community and stakeholders to develop appropriate instruments to gather the data necessary for evaluation. **The County may wish to outline their plans for sharing and disseminating lessons learned and results of the pilot project.**

The Budget

Los Angeles County is requesting up to \$116,750,000 of innovation funds for the duration of 5 years to temporarily replace the existing MHSA/Medi-Cal based funding system within the geographical boundary of Hollywood, CA. It should be noted that the County is requesting flexibility in the budget details as they plan to engage in a robust stakeholder process to determine how the community wants to design a responsive system and they do not yet know how many FTE positions in each category there will be. Due to these factors, they are requesting a 10% variance to adjust allocations within the approved budget.

The County is requesting \$11,850,000 for year one to use for planning purposes and \$26,225,000 for each of the remaining 4 years for implementation and evaluation.

In the planning year (July 1, 2019 – June 30, 2020), the \$11,850,000 is budgeted for: one-time infrastructure investment including improving facilities to provide new transitional housing beds, peer respite, crisis residential and 10 slots at an urgent care; designing, implementing and supporting electronic health record technology; extensive training for staff on the new EHR and on evidenced-based psychosocial practices; \$2,500,000 for consultation to support the shift from a medical model to a psychosocial model (**see table 5 on pge. 45 for a list of experts included in the consultation**); evaluation design and set up; and community resource development.

Years 2 through 5 (July 1, 2020 – June 30, 2024) are budgeted at \$26,225,000 per year, which reflects the current cost of all adults served in the geographic region over the 2017-18 fiscal year (approximately \$18,000,000); evaluation costs and funds for additional services.

The majority of the budget is invested in staffing (\$16,900,000 per year) and operation costs (\$6,800,000 per year) with a total of \$4,750,000 (4%) allocated for evaluation.

Addressing sustainability, the County anticipates that the pilot will be successful and plans to expand the model across the county behavioral health system stating that “[a]ssuming positive outcomes from the pilot, the County will make the services an ongoing part of its annual request for MHA CSS funds and anticipates drawing down matching FFP to serve as the main source of funding in the future” (see pge. 53 of County plan).

While this is a large investment of Innovation funds, it may be helpful to consider that the request is closely matched with the current amount being spent on mental health services in this geographic region.

Additional Regulatory Requirements

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

Full project proposal can be accessed here:

<https://mhsoac.ca.gov/document/2019-05/los-angeles-county-trieste-innovation-project-may-23-2019>

References

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Ragins, Mark (2016). MHA Village Retrieved from <https://www.psychologytoday.com/us/blog/rethinking-mental-health/201603/mark-ragins-mha-village?amp>

Los Angeles County-TRIESTE

EXECUTIVE SUMMARY

The concept of recovery has become the dominant paradigm for the provision of mental health services. Nearly everybody with mental health challenges, even those with the most severe impairments, is considered capable of “a life in the community not defined by their mental illness.” The Mental Health Services Act – the defining document for the provision of mental health services in California – requires an approach that goes beyond treating the symptoms of the illness and instead focuses on ensuring that people with mental illnesses have appropriate housing, social connection and belonging and purpose in their lives.

And yet, for all the acceptance and promotion of the recovery model, the actual on-the-ground results appear to be mixed at best. The increasing numbers of homeless people with a mental illness and the system’s relative inability to help people to achieve true community inclusion both suggest that there is something missing in the way that the recovery vision is being implemented.

It is our premise that the single greatest reason for our system’s failure to deliver on the promise of the recovery model is to be found in the way that we finance mental health care in the United States. At its core, the U.S. mental healthcare system is driven by two closely related factors:

- (1) compliance with the Medicaid-based fee-for-service payment system and its copious associated regulatory processes that are intended to ensure accountability, and
- (2) an over-emphasis on the treatment and mitigation of the symptoms of the illness rather than on the well-being of people served and their re-integration into the community at large.

In essence, our current payment and funding systems – presumably out of their concern for “fiscal accountability” – constrain and restrict our best intentions to actually meet the needs of the people we serve. If the recovery model is to ever actually fulfill its promise, we must create new and innovative payment, accountability and documentation systems that free us from the bureaucratic constraints that prevent us from providing the services that people actually want and need.

This MHSA Innovation Project proposes to implement five related innovations to create a pilot project that will demonstrate how both individual and system outcomes and consumer satisfaction in our mental health system can be dramatically improved without increasing the cost of services.

These five innovations are:

- A. A Recovery-Informed Reimbursement System
- B. Recovery-Informed Documentation and Process-Monitoring
- C. Recovery-Informed Performance Measurement
- D. Shifting to the Provision of “Well-Being-Focused” Services
- E. Technology that supports payment, documentation and accountability reforms

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While for narrative reasons we will address each of these innovations in turn, it is important to note that we believe that these innovations are closely-related and all are necessary components of a true recovery-informed systems approach.

Background

In late 2017, a group of thirteen Los Angeles County officials and leaders took on the task of examining the reasons for the suboptimal performance of the mental health system in the Los Angeles County. In November of that year, the group (hereafter referred to as “the Tribe”) visited Trieste, Italy, to attend an international conference, “The Right and Opportunity to Have a Whole Life” and study the local mental healthcare system which is recognized as an exemplary system by the World Health Organization and celebrated by experts in the field. Among the many key observations made during their visit: 1) there are essentially no homeless people with a mental illness in Trieste; 2) the jails are not overcrowded with inmates with a mental illness, and; 3) involuntary psychiatric care has been virtually eliminated.

Though there are surely a multitude of factors accounting for these observations that contrast so dramatically with L.A. County, it is our contention that the most significant reasons for the differences in outcomes are 1) the ways the two systems are financed and 2) the enormous difference in their bureaucratic, regulatory and reporting requirements. The staff in Trieste are blissfully unaware of and unconcerned with how the services they provide are paid for. Staff are able to do “whatever it takes” because they are not concerned that an audit will determine that the service they provided did not meet the criteria for “medical necessity.” And staff do not spend anywhere near the 25% of their time documenting the services they provide that is typical in Los Angeles.

INNOVATION A: A Recovery-Informed Reimbursement System

Unlike the capitated system of Trieste, our public mental health reimbursement system is characterized by a fee-for-service reimbursement model that requires staff to bill by the minute (or hour or day, depending on the service). This reimbursement model diverts staff attention away from the care they are providing and the needs of the members they are serving to whether they are meeting their “billing goals.”

Furthermore, the fee-for-service reimbursement model creates a perverse incentive to provide more services (greater volume) than may be actually necessary for the member because the provider gets paid more as the amount of service increases. Because of the individual staff person’s need to provide billable hours, it becomes tempting to provide additional services even though they may not be needed or desired by the member.

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We believe that a reimbursement system that provides funding based on the outcomes of services (paying for value) rather than for the quantity of services provided (paying for volume) is best suited to provide the financial and accountability underpinnings for a true recovery-oriented system of mental health services. Therefore, we intend to implement a multi-tiered case rate system in which funding is based on the level of need of the persons served and is completely uncoupled from the amount of service provided. This approach will encourage and empower our caregivers to attend more flexibly to the successful personal recovery and community integration goals of those with serious mental health problems instead of forced compliance with relentless regulatory processes.

INNOVATION B: Recovery-Informed Documentation and Process Monitoring

The pilot project will implement a process-monitoring and documentation system that encourages staff to relate to their members as whole people rather than just to their illness. To promote the provision of well-being-focused rather than illness-focused services, we propose to completely eliminate the current Medicaid service classification system and replace it with a monitoring system that addresses all aspects of the member's quality of life as well as describing what the staff person actually did in his/her interaction with the member. All services will be designed to help members achieve the following goals:

- (1) A safe and healthy home in the community (HOME & HEALTH),
- (2) Acquiring and maintaining familial, social and intimate relationships (LOVE AND BELONGING), and
- (3) Acquiring and maintaining meaningful roles in the larger community (PURPOSE).

Implementation of this system will ensure that staff are addressing the needs of the whole person – not just the illness – as well as having the effect of significantly reducing documentation time and increasing time for the actual provision of care.

INNOVATION C: A Recovery-Informed Performance Measurement System

Our current system is characterized by a focus on monitoring (and paying for) services based on the quantity of the services provided regardless of their effectiveness. The pilot will shift away from this type of process monitoring by fully implement the existing Key Event Tracking System (KETS) currently used by the State of California to track outcomes for Full Service Partnership (FSP) programs. These indicators will enable us to judge the pilot's effectiveness in increasing independent living and employment and reducing rates of incarceration and hospitalization in the population served.

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In addition, we propose to implement a two-component system that measures our pilot's effectiveness in helping our members to develop the skills and the supports that they need to live in the larger community. The components of this system are the Milestones of Recovery Scale (MORS) and the Determinants of Care. The MORS defines recovery beyond symptom reduction, client compliance and service utilization. It sees meaningful roles and relationships as the driving forces behind achieving recovery and leading to a fuller life. The Determinants of Care help staff to understand which specific life domains the member is able to self-coordinate and the domains for which s/he needs either natural or professional support. Over time, it is expected that the member will learn to self-coordinate more aspects of his/her life.

The pilot will be able to evaluate its effectiveness in helping our members to become more self-coordinating, which in turn is expected to help the member to live more successfully in the larger community.

INNOVATION D: The Proposed Service Array: Shifting the Balance from “Illness-focused” Services to “Well-being-focused” Services

The most foundational service offered in the pilot will be to act as the member's health home in which both the mental and physical healthcare needs of the member can be addressed. Members will be assigned to a health home that reflects and is congruent with their level of need and their ability to self-coordinate their care. Wellness and Peer-Run Centers, Outpatient Clinics and FSPs could all serve as the health home for the member, with each of these levels of care providing the appropriate (i.e., needed) amount of assistance for the member to achieve the maximum level of independence in the community.

It is our belief that implementing innovations A, B, and C will create the financial and regulatory environment in which true, recovery-oriented, well-being focused services are most likely to thrive and achieve their intended effect. But to increase the likelihood of the success of this endeavor even further, the pilot intends to employ a trauma-informed, culturally competent approach that reverses the usual emphasis between clinical and psychosocial services by making the psychosocial services “primary” and the clinical services “ancillary.” For example, a wide variety of supported employment and supported education services will be available as well as an emphasis on leisure and recreational opportunities. But in all services offered, staff will be aware of the significant roles that trauma and racial, ethnic and gender disparities play in the lives of the people we serve.

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While we of course recognize that many of the members we serve require very high levels of traditional clinical services and supports (e.g., therapy, medication support), we also believe that we must constantly remind ourselves of and focus on the whole life the member is trying to lead in spite of having a severe and persistent mental illness. It will be the extensiveness and robustness of these psychosocial, non-illness centered services that will to a large degree determine our success in this endeavor.

The pilot will also implement new levels of crisis and emergent services including Peer Respite, Crisis Residential, and Urgent Care that currently do not exist in the proposed pilot region.

INNOVATION E: Technology that supports documentation, accountability and payment reforms

The Reimbursement/Documentation/Accountability system proposed in Innovations A – C will require a significant investment in technology to realize its potential to reduce the documentation burden on staff and improve the effectiveness of care. We envision a HIPAA-compliant electronic health record that is accessible through a smart phone application. Staff will record not only their interactions with individual members but ALL the activities in their work.

Data will be entered into the EHR database either wirelessly or when staff return to the facility and dock their phone with the system.

It is expected that this voice-enabled system will reduce keyboard data entry by as much as 90% and thereby reduce the data entry time for staff by several orders of magnitude. It also has the benefit of being much more accurate and reliable in that it requires staff to enter their documentation on an ongoing, real-time basis.

SUMMARY

For at least 30 years, the recovery model has held out the promise of a system that will achieve true community inclusion for people who are marginalized by their experience with severe and persistent mental illnesses. That promise remains unfulfilled. It is our belief that the primary reason it remains unfulfilled is that our bureaucratic and regulatory systems have not kept pace with or supported our improved approaches to service. This innovation proposal offers a roadmap as to how to create a “recovery-oriented bureaucracy” – which we do not believe to be an oxymoron! To the contrary, we believe that the innovations described here will improve our effectiveness (better outcomes) and will increase both staff morale and member satisfaction with the experience of care.

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We believe that ultimately this project has the potential to transform the mental health system in the United States. We respectfully request that the Oversight and Accountability Commission fund this proposal and thereby “liberate the recovery angels of our nature.”

BUDGET

This proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) aims to obtain approval for the resources we need to administer and study a pilot system over a five-year period. In the first year of the project (July 1, 2019 – June 30, 2020), \$11,850,000 is budgeted to reflect upfront, one-time infrastructure investment for purchasing and renting facilities as well as designing, implementing and supporting electronic health record technology. The first year of the project will be used to engage community stakeholders, secure all necessary regulatory waivers, establish evaluation contracts and protocols, and site new services.

New services will actually begin on July 1, 2020 and the pilot will run through June 30, 2024. The baseline annual budget will be \$26,225,000 per year which reflects the current cost of all adults served in the geographic region over the 2017-18 fiscal year (approximately \$18,000,000) plus the funds needed to add a number of new services plus the cost of the evaluation of the pilot.

Thus, total funding requested for the entire five-year innovation project totals \$116,750,000 (\$11,850,000 + (\$26,225,000 * 4 years)).

Within three years of launching the pilot, we anticipate that we will begin to see not only improved outcomes and customer satisfaction among the members we serve, but will also see improved morale among service providers. It is our hope and expectation that within five years we will achieve sufficient proof of concept to feel confident expanding the model across our county’s mental health system. Ultimately, we are hopeful that the model will be so successful that we will be able to convince not only the state of California but also the federal government that the Medicaid financing and accountability system should be changed to reflect what we demonstrate through this project in Los Angeles County.

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Proposed Timeline for Implementation – First 20 Months

November, 2018

- Initial draft of concept paper completed

December, 2018

- Determination of the geographic boundaries of the pilot

March, 2019

- “Final” draft of concept paper completed
- Determination of the precise population to be served and initiation of economic analysis of current county expenditures for the population
- Expanded stakeholder process to vet concept paper begins
- Submission of concept paper to MHSOAC

April, 2019

- Initial presentation to members of the MHSOAC

May, 2019

- Submission of full proposal for five year innovation grant to the MHSOAC with expectation that grant will be awarded to begin effective July 1, 2019 through June 30, 2024.
- Initial discussions/negotiations with potential independent evaluators to determine scope and cost of the evaluation
- Initial discussions/negotiations with potential EHR vendors to determine scope and cost of the new EHR.
- MHSOAC officially awards Innovation Grant (MH Month!)

July 1, 2019 – June 30, 2020

- Securing all necessary regulatory waivers
- Expanded stakeholder process to determine scope and implementation of services
- Selection of independent evaluator and implementation of evaluation protocols
- Selection of EHR vendor and implementation of system
- Initial training of staff on all data collection and accountability systems

July 1, 2020

- Doors open and services begin under the pilot project.

AGENDA ITEM 5

Action

May 23, 2019 Commission Meeting

Streamline Commission Approval of Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission will consider options for streamlining procedures for approval of County Innovation Project work plans.

During the April 25, 2019 Commission meeting, the Chair directed staff to prepare for consideration at the May 23, 2019 meeting options for streamlining the Commission's review and approval of County Innovation Project work plans. This direction was in light of Commissioner concerns that Innovation approvals were consuming a disproportionate share of the Commission's formal meeting time, to the exclusion of other activities.

Presenter:

- Brian R. Sala, Ph.D., Deputy Director, MHSOAC

Enclosures: None.

Handouts (2): (1) Staff Brief on Options for Streamlining Review of County Innovation Project Work Plans; (2) A PowerPoint presentation will be presented at the meeting.