WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
July 27, 2023
Presentations and Handouts

Agenda Item 6:	•Handout:	Panelist Bios
	•Handout:	Letter from California Alliance to The Honorable Jim Wood
	•Presentation:	Preserving Children and Youth Services in BHSA
	•Presentation	MHSA "Modernization" - Threat to Community-Defined Evidence-Based Practices & Peer Support Programs
	•Handout:	LAO Key Takeaways
Agenda Item 8:	•Presentation:	Why Meaningful Community Engagement Matters & Best Practices
	•Handout:	Principles of Community Engagement
	•Handout:	Assessing Meaningful Community Engagement in Health & Health Care Policies & Programs Project
	•Handout:	Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health
	•Handout:	Solano County Interdisciplinary Collaboration and Cultural Transformation Model Innovation Project: Final Evaluation Report
Agenda Item 9:	•Presentation:	Universal Mental Health Screening of Children and Youth Project Plan Proposal
Agenda Item 10:	•Presentation:	MHSOAC Budget Overview and Expenditure Plan
Miscellaneous:	•Handout:	12-Month Rolling Commission Meeting Calendar (Tentative)

Agenda Item o ĸMHSA Modernization Proposal
Panelist Biographies

- **Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)**

Stephanie Welch is the Deputy Secretary of Behavioral Health for the California Health and Human Services (CalHHS) Agency. In this role she acts as a senior advisor to the Secretary of CalHHS and other state departments on behavioral health policy. In addition, the Deputy Secretary builds bridges across various government sectors and with stakeholders from diverse perspectives. Prior to this role, Stephanie was the Executive Officer of the Council on Criminal Justice and Behavioral Health (CCJBH) based in the Office of the Secretary at the California Department of Corrections and Rehabilitation (CDCR). Stephanie has over two decades of experience in mental health policy, program administration, evaluation and advocacy at both the state and county level, working at organizations such as the California Mental Health Services Authority (CalMHSA), the County Behavioral Health Directors Association (CBHDA) and the California Council of Community Behavioral Health Agencies (CBHA). Stephanie approaches her work improving systems by examining the impact to individuals and communities, always striving for better-quality experiences and outcomes. Stephanie holds an MSW from the University of Southern California and a BA in Sociology from the University of California, Davis.

- **Jacey Cooper, Chief Deputy Director & State Medicaid Director, California Department of Health Care Services**

Governor Gavin Newsom appointed Jacey Cooper as State Medicaid Director and Chief Deputy Director for Health Care Programs at the Department of Health Care Services (DHCS) effective January 31, 2020. Ms. Cooper is responsible for the overall leadership of Benefits, Eligibility, Delivery Systems, Financing, Behavioral Health, Quality and Population Health. As State Medicaid Director, Ms. Cooper represents California's Medicaid program (Medi-Cal) with federal partners at the Centers for Medicare & Medicaid Services. Prior to serving as State Medicaid Director, Jacey served in various roles at DHCS beginning in April 2016.

Prior to her work at DHCS, Ms. Cooper was Vice President of Administrative Services at Kern Medical Center and a health care consultant. Through that work, she gained more than 15 years' experience in health care policy, operations, integrated delivery models, managed care, business development, and quality monitoring.

- **Vitka Eisen, Chief Executive Officer, HealthRIGHT 360**

Vitka is the President and Chief Executive Officer of HealthRIGHT 360, a healthcare provider for very low income and otherwise marginalized Californians. With over 30 years of experience in human services, Vitka has dedicated her career to supporting people and communities struggling with addiction and incarceration through the provision of integrated, compassionate, and relevant care. Since being appointed to her current role in 2010, Vitka has led HealthRIGHT 360 through a series of mergers, growing the organization to serve over 30,000 people annually.

A frequent speaker on innovative practices, Vitka is the president of the board of directors of the California Council of Community Behavioral Health Agencies, the vice president of the board of directors of the California Association of Drug and Alcohol Program Executives, and a member of the board of directors of the National Council for Behavioral Health. Vitka earned an M.S.W. from San Francisco State University, and a Doctorate from the Harvard Graduate School of Education.

Vitka is a former injection heroin user; she participated in substance use disorder treatment over 30 years ago at the agency she now leads.

- **Le Ondra Clark Harvey, Chief Executive Officer, California Council of Community Behavioral Health Agencies**

Dr. Clark Harvey is a psychologist and the Chief Executive Officer of the California Council of Community Behavioral Health Agencies a statewide advocacy organization representing mental health and substance use disorder non-profit agencies that collectively serve over 750 thousand Californians annually. She is also the Executive Director of the California Access Coalition- a group of advocacy organizations and pharmaceutical industry companies that advocates for patient access to behavioral health treatment. Dr. Clark Harvey has previously served as Chief Consultant to the California State Assembly Committee on Business and Professions, Principal Consultant to the Senate Committee on Business, Professions and Economic Development, and a health policy consultant to the office of former Senator Curren D. Price, Jr.

Prior to her work within the California Legislature, she completed her Ph.D. in Counseling Psychology at the University of Wisconsin, Madison. She completed her pre-doctoral fellowship at the University of Southern California Children's Hospital Los Angeles and a post-doctoral fellowship at the University of California, Los Angeles Mattel Children's Hospital.

Dr. Clark Harvey has maintained an impressive record of leadership including serving on national and local boards including the American Psychological Association (APA), and prior positions on the Association of Black Psychologists, Sacramento County Public Health Advisory Board and the Sacramento County Children's Coalition. Dr. Clark Harvey has received numerous awards and in 2020, was appointed by California Governor Gavin Newsom to his Master Plan on Aging Advisory Committee and the Behavioral Health Task Force. In 2021, she was appointed by California Lieutenant Governor Eleni Kounalakis to the California Institute for Regenerative Medicine Board.

- **Jolie Onodera, Senior Legislative Advocate, California State Association of Counties**

Jolie Onodera is the Senior Legislative Advocate covering health and behavioral health issues for the California State Association of Counties (CSAC), which represents all 58 counties of the state. Prior to joining CSAC, Ms. Onodera served as the Legislative Director for the California Department of Finance from 2018 to 2022, where she advised the Director of Finance and the Governor's Office in the evaluation and implementation of legislative issues affecting the state budget and the state's fiscal condition. Ms. Onodera was appointed and served as the Deputy Secretary of Legislation at the California Business, Consumer Services and Housing Agency during 2017-2018. Prior to her appointment, she served as principal consultant for the California State Senate Committee on Appropriations from 2011-2016, where she worked on public safety, judiciary, and human services issues. Her past experience also includes positions with the California Department of Social Services, the Managed Risk Medical Insurance Board, and the Department of Financial Protection and Innovation.

- **Christine Stoner-Mertz, Chief Executive Officer, California Alliance of Child & Family Services**

Christine Stoner-Mertz, LCSW, is the CEO of the California Alliance of Child and Family Services and its Catalyst Center. The Alliance is a 160 member association that serves as the collective voice for organizations that serve children, youth and families throughout California. As a clinician, administrator, and former foster parent, Ms. Stoner-Mertz brings her personal and professional expertise to the policy and practice efforts of the Alliance and Catalyst, a training and technical assistance program focused on practice improvement in children and family services. Previously, Ms. Stoner-Mertz served as President and CEO of Lincoln, an agency delivering a range of community-based services in the San Francisco Bay area. She has served on state and national boards of behavioral health associations, and has worked as a consultant to numerous nonprofits, county departments and the State of California. Ms. Stoner-Mertz was a co-founder of Seneca Family of Agencies, a state-wide nonprofit. A sought-after expert on MediCal EPSDT program design and implementation, she has expertise in integrating funding streams to effectively address the behavioral health needs of children, youth and families.

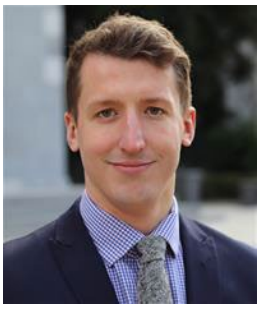
- **Andrea Wagner, Interim Executive Director, California Association of Mental Health Peer Run Organizations**

Andrea Wagner, Interim Executive Director for CAMHPRO (CA Assoc. of Mental Health Peer Run Organizations), was inspired and mentored by founding director and pioneer leader in the mental health peer movement, Sally Zinman. Previously, during five years employed at Butte County Crisis Services, Andrea continued local advocacy efforts for peer support services that resulted in wage increases, permanent full-time peer jobs, and a re-classification of peer support specialists in the county. Her efforts also supported Northern Valley Talk Line and the development of the Diverse Minds North State program of Iversen Wellness and Recovery Center. Andrea has a bachelor's degree in journalism and a master's in public administration from USC Price Sacramento. She currently lives in Chico with her son and an incredibly devious cat named Jeff.

- **Ryan Miller, Principal Fiscal & Policy Analyst, Legislative Analyst's Office**

Ryan Miller re-joined the Legislative Analyst's Office (LAO) in January 2023 and covers issues related to behavioral health and health care access and affordability. From 2018 to 2022, Ryan worked at the Department of Finance where he initially led the health care team and later the forecasting unit. Ryan's prior work at the LAO, from 2012 to 2018, focused on taxes, pensions, and the overall state budget condition. From 2008-2012, Ryan worked at the Congressional Budget Office, estimating the costs of federal mandates on state and local governments in the areas of energy, environment, and transportation. Ryan has a Master's in Public Policy degree from George Washington University and bachelor's degrees in economics and public policy from Michigan State University.

- **Will Owens, Fiscal & Policy Analyst, Legislative Analyst's Office**



Will Owens joined the Legislative Analyst's Office September 2022 after working for the California Department of Housing and Community Development and the California Department of Education. Prior to his work in California, Will was an analyst with the New Jersey Office of Legislative Services covering K-12 education funding. In his current role, Will covers the Department of Public Health, Department of State Hospitals, Emergency Medical Services Authority, Mental Health Oversight and Accountability Commission, CalAIM, and various behavioral health issues, including the Mental Health Services Act. Will has Master's degrees in Public Policy and City and Regional Planning from Rutgers University and a bachelor's degree in Urban Environmental Studies from Birmingham-Southern College.

July 6, 2023

The Honorable Jim Wood
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

RE: SB 326 (Eggman) Behavioral Health Services Act.– CONCERNS

Dear Chair Wood:

On behalf of the California Alliance of Child and Family Services (the California Alliance), we respectfully must share our concerns regarding SB 326 (Eggman) – The Behavioral Health Services Act. Without the revisions we recommend below, this legislation is likely to cause **severe cuts** in critical services for children and youth and undermine California's efforts to address a youth mental health crisis the U.S. Surgeon General has called "alarming," "devastating," and also "preventable."

The California Alliance represents over 160 nonprofit, community-based organizations serving children, youth and families through behavioral health, education, foster care, prevention, and juvenile justice programs throughout the state. Our member agencies are on-the ground service providers delivering lifesaving services funded by the MHSA, in addition to delivering Medi-Cal behavioral health services. In a June 2023 survey of Alliance members, over half of the respondents stated that they operate programs funded by the Prevention and Early Intervention (PEI) component of the MHSA. PEI funding supports a diverse range of essential services including: parent education and family counseling programs; "drop in" centers for transition-aged youth; Early Psychosis Intervention programs, Family Resource Centers, etc. In addition, more than half of the respondents provide services funded by MHSA Community Services and Supports (CSS). CSS programs support adults with serious mental illness and youth with serious emotional disturbance (SED). Statutorily, at least half of CSS funding must provide Full-Service Partnerships (FSPs), a comprehensive, client-driven, "whatever it takes" approach to help individuals achieve wellness.

Our members recognize and support the need to update some aspects of the MHSA. Most importantly, we strongly support the proposal to include services for individuals with substance use disorder (SUD) treatment needs, regardless of whether they have a co-occurring mental illness. Additionally, we understand the focus on individuals experiencing homelessness with behavioral health needs; however we reject this proposal's construction of a false choice between homelessness now and homelessness later. Taking resources from critical mental health services for children and youth will only subject more vulnerable Californians to the trauma of life on the streets, especially since the vast majority of individuals develop mental illness prior to 25.

The proposed revisions to the MHSA include a new funding allocation of 30% reserved for housing supports,[1] which shifts funding away from other vital MHSA services, including many programs serving children and youth. To avoid the loss of these essential programs and the resulting harm to youth, we recommend creating several funding allocations reserved for programs that support children and youth, as discussed below.

[1] Governor Newsom's Transformation of Behavioral Health Services Fact Sheet, June 22, 2023.

Dedicated Set-aside for Services for Children and Youth

Currently, about 10% of MHSA funding (approximately $321.6 million in FY 22-23) is allocated to PEI programs for youth, since 51% of PEI funding (which represents 20% of MHSA funding) must be spent on children and youth up to age 25.[2] The proposed reforms will lead to **a significant decline in funding for PEI programs for children and youth**.

SB 326 contains *no set aside for PEI programs for children and youth.* While the proposal would allocate 15% of total funding for Early Intervention services and 5% for population-based preventive services,[3] nothing in the proposal would prevent a county from spending most of these resources on adults. In addition, the expansion of the target population to include individuals with SUD will further dilute funding for these services. Therefore, without a specific set aside for PEI services for youth, many of these programs will likely be forced to close or reduce programming for children, youth, and families across the state.

The Administration argues that fewer PEI programs are needed because the Children and Youth Behavioral Health Initiative (CYBHI) school-based fee schedule will offer preventive and early intervention behavioral health services for students. The CYBHI fee schedule, however, will offer a single set of *standardized* services that can be delivered by both Medi-Cal and commercial plans. MHSA PEI funding, in contrast, supports a diverse array of interventions that can be tailored to the unique needs of a particular underserved population, such as a program designed for Latinx families or LGBTQ+ youth, or an Early Psychosis Intervention program. In addition, many PEI programs are better suited to support an entire family, such as parenting programs like Parent-Child Interaction Therapy and Family Resource Centers. The benefits of these programs provide a tremendous Return on Investment in communities. For example, supports stewarded by Family Resource Centers reduce child abuse and neglect in communities and produce significant fiscal savings through the reduction of referrals to Child Protective Services (CPS) and subsequent mandated programing and services, netting Child Welfare Systems statewide with a 365% return on investment for every dollar spent.

We are also concerned about currently planned restrictions on the type of services available via the CYBHI fee schedule; the current Department of Health Care Services (DHCS) proposal, for example, would exclude case management services for youth enrolled in Medi-Cal.

- ✓ **We therefore recommend that, in order to preserve current funding for essential PEI programs for youth, the proposed reforms allocate: 1) 50% of the Early Intervention funding for youth (ages 25 and younger) and 2) 50% of the population-based prevention services for youth.**

- ✓ In addition, the Legislature should ensure funding is set aside from BHSA to sustain CYBHI's level of investment in services for youth upon the expiration of services funded by CYBHI.

[2] Currently, 19% of total MHSA funding is allocated to PEI programs (about $630.5 million in FY 22-23). Governor Newsom's Transformation of Behavioral Health Services Fact Sheet, June 22, 2023. Fifty-one percent of those monies, or about 10% of total MHSA funding, must be allocated to PEI programs serving children, youth and young adults (aged 25 and younger). 9 CCR §3706.

[3] The proposal would allocate 30% of total funding for "Behavioral Health Services and Supports," with a requirement that a majority of those funds be spent on Early Intervention programs.

Full Service Partnership Set-Aside for Children and Youth

Full Service Partnership (FSP) programs provide essential services and supports to youth who are transitioning from or at risk of entering out-of-home placements, such as juvenile hall, foster care and psychiatric emergency facilities. In FY 20-21, nearly half (48.3%) of beneficiaries receiving FSP services were children and Transition Aged Youth.[4] Under the proposed reforms, 35% of MHSA funding would be reserved for FSP programs. However, with the expansion of the target population to include individuals with SUD needs, as well as the Governor's plan to allocate FSP slots to support CARE Court programs, available funding for FSP programs for youth will clearly be crowded out by these additional demands on the BHSA's finite pool of dollars.

- ✓ **We strongly recommend that the proposed reforms require that at least 50% of the FSP allocation be earmarked for programs serving children and youth ages 25 and younger.**

Housing Supports for Children and Families

Our members appreciate the vital importance of alleviating California's housing crisis; every day our members serve families struggling to maintain housing. In fact, data shows that **about one in four** Californians who struggle with homelessness are unaccompanied youth or families with children.[5] These individuals, who may be sleeping in a car, "couch-surfing" in the home of a friend, or living in severely substandard housing, are often less publicly visible than adults living in encampments. Yet families and unaccompanied youth are equally in need of adequate housing. Housing supports for children and youth, moreover, can be particularly effective early interventions that will help these individuals avoid becoming chronically homeless. In addition, 1 in 4 California foster youth become homeless after existing the foster care system. These already vulnerable youth are facing unprecedented new challenges.

We are therefore very concerned that the proposed allocation of 30% of total MHSA funding for housing supports would set aside 50% of that allocation for "persons who are chronically homeless, with a focus on those in encampments."[6] This funding would apply primarily to adults, who are much more likely to meet the definition of chronically homeless (e.g. homeless for at least 12 months) and to live in public encampments.

- ✓ **In order to ensure that children and families receive an appropriate share of housing interventions, we recommend that 25% of housing supports be allocated to programs serving youth and families.**

We are also concerned about the proposed requirement that housing programs for youth must prioritize individuals who have SED or SUD[7] -- in addition to facing one of the following risk factors: experiencing or at risk of homelessness; child welfare or juvenile justice system involvement, or being at risk of

[4] Mental Health Services Oversight and Accountability Commission website, Transparency Suite, Full Service Partnerships.
[5] The Governor's Homeless Plan, LAO Report, February 2022, states that 16% of Californians experiencing homelessness are families with children and an additional 8% are youth under 24. If youth ages 24 and 25 are added to this statistic, the total number would likely be at least 25% of all individuals experiencing homelessness.
[6] Senate Bill (SB) 326, Section 86 (adding §5892(a)(1)(A)(ii) to the Welfare and Institutions [WIC] code.)
[7] SB 326, Section 86 (adding §5892(c))(2) to the WIC Code.

institutionalization. Youth face homelessness for a variety of reasons, many of which are unrelated to an SED or SUD. LGBTQ+ youth, for example, are disproportionately represented among the homeless youth population.[8] Similarly, many young people exiting the foster care system struggle to find stable housing, regardless of whether they have an SED or SUD. It is well recognized, moreover, that homelessness itself is a traumatic experience that creates a higher risk of mental health and SUD conditions.

The SED/SUD requirement for housing flies in the face of the Administration's push toward earlier interventions for youth, particularly the sweeping ACES initiative, which aims to avert the impact of trauma on adverse outcomes for youth later in life, including homelessness. Similarly, the CalAIM initiative has removed SED diagnosis as a condition for treatment for children and youth.

In addition, the criteria for an SED[9] are both detailed and restrictive, requiring a formal mental health diagnosis and documentation of additional criteria, such as "substantial impairments" in multiple areas or a risk of harm to self or others. As a result, the need to document a youth's SED would add significant additional paperwork burdens without necessarily helping programs prioritize youth most in need of housing supports.

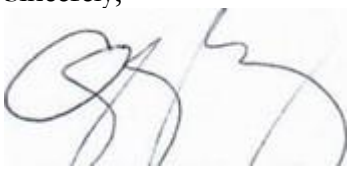
- ✓ **We therefore recommend removal of the SED (or SUD) criterion for youth, in order to enable programs to more effectively prioritize youth most in need of housing supports.**

Reporting on Children and Youth Allocations

Lastly, any reform should include robust and specific reporting to the Legislature and stakeholders on BHSA funding delivered to children's programs (0-25) to ensure legislative intent has been fulfilled.

We appreciate this opportunity to share these concerns with the Assembly Health Committee. We look forward to continuing to discuss how the MHSA can be improved to best meet the needs of California's most vulnerable populations.

Sincerely,



Christine Stoner-Mertz, LCSW
Chief Executive Officer

CC: Honorable Members, Assembly Health Committee
The Honorable Susan Eggman, Author
Judy Babcock, Principal Consultant, Assembly Health Committee
Lisa Murawski, Principal Consultant, Assembly Health Committee

[8] California's Homeless Youth, California Coalition for Youth Website. Accessed on June 29, 2023 at: https://calyouth.org/advocacy-policy/Californias-homeless-youth/
[9] Welfare and Institutions Code Section 5600.3.

Preserving Children and Youth Services in BHSA

MHSOAC Presentation

July 27, 2023

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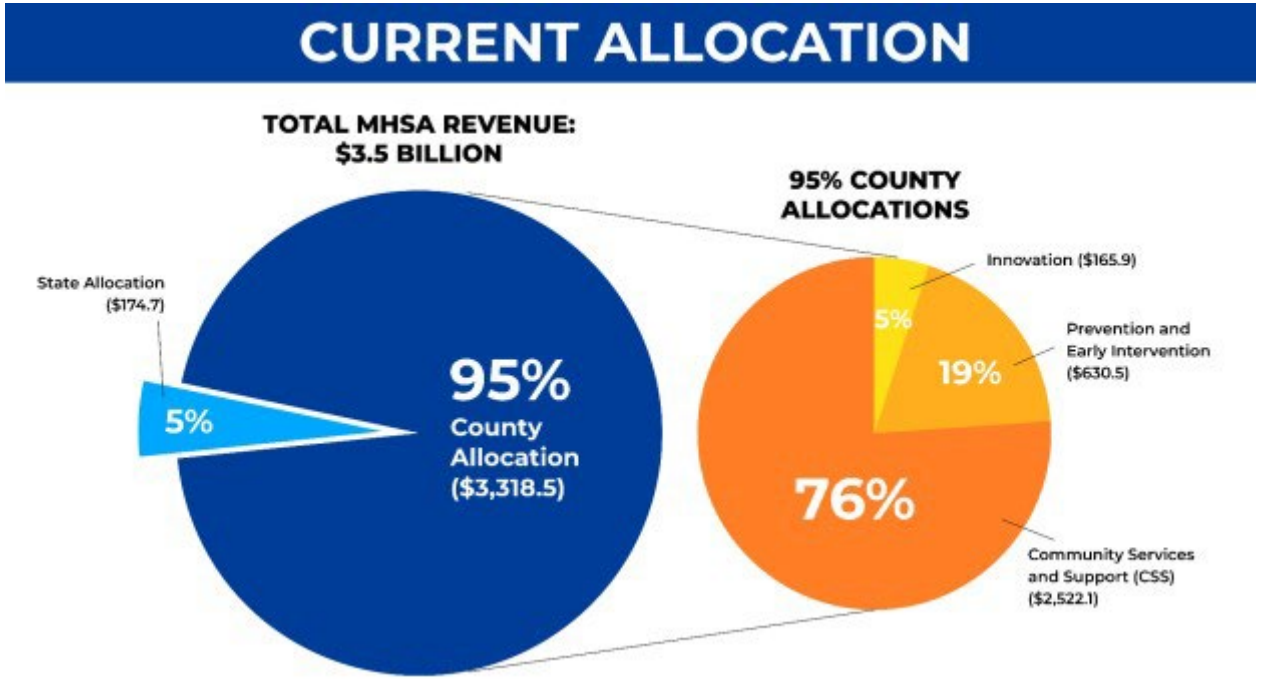
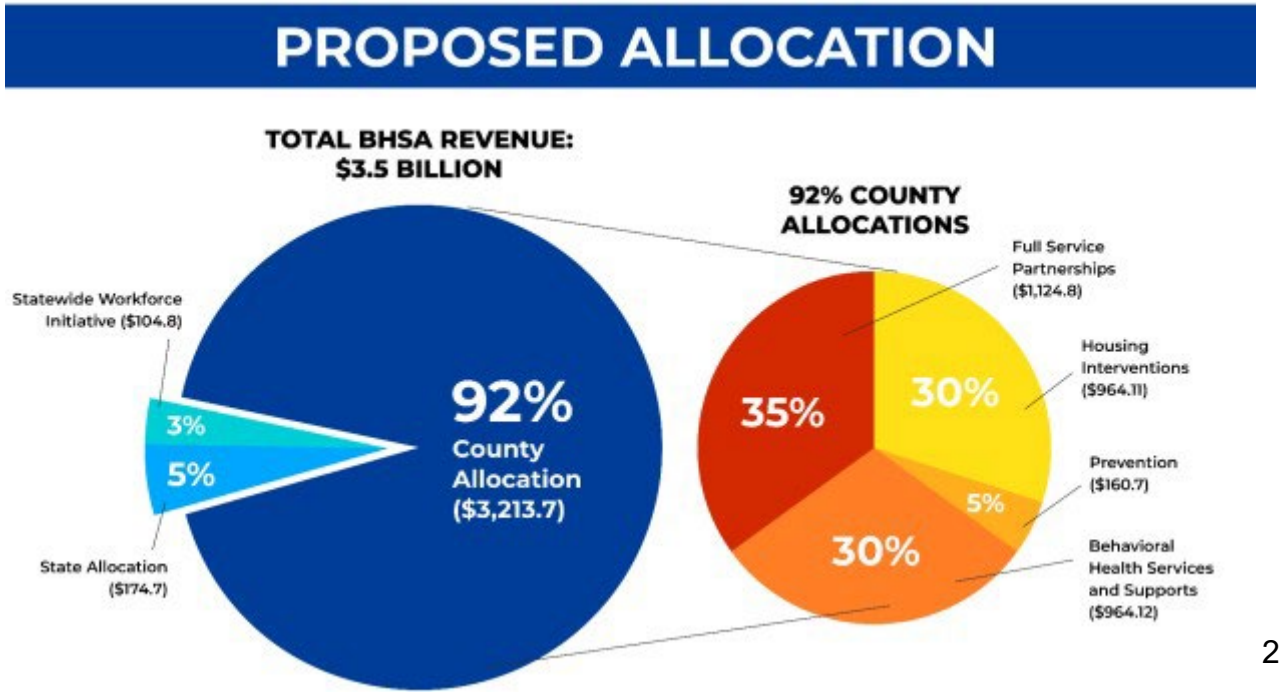
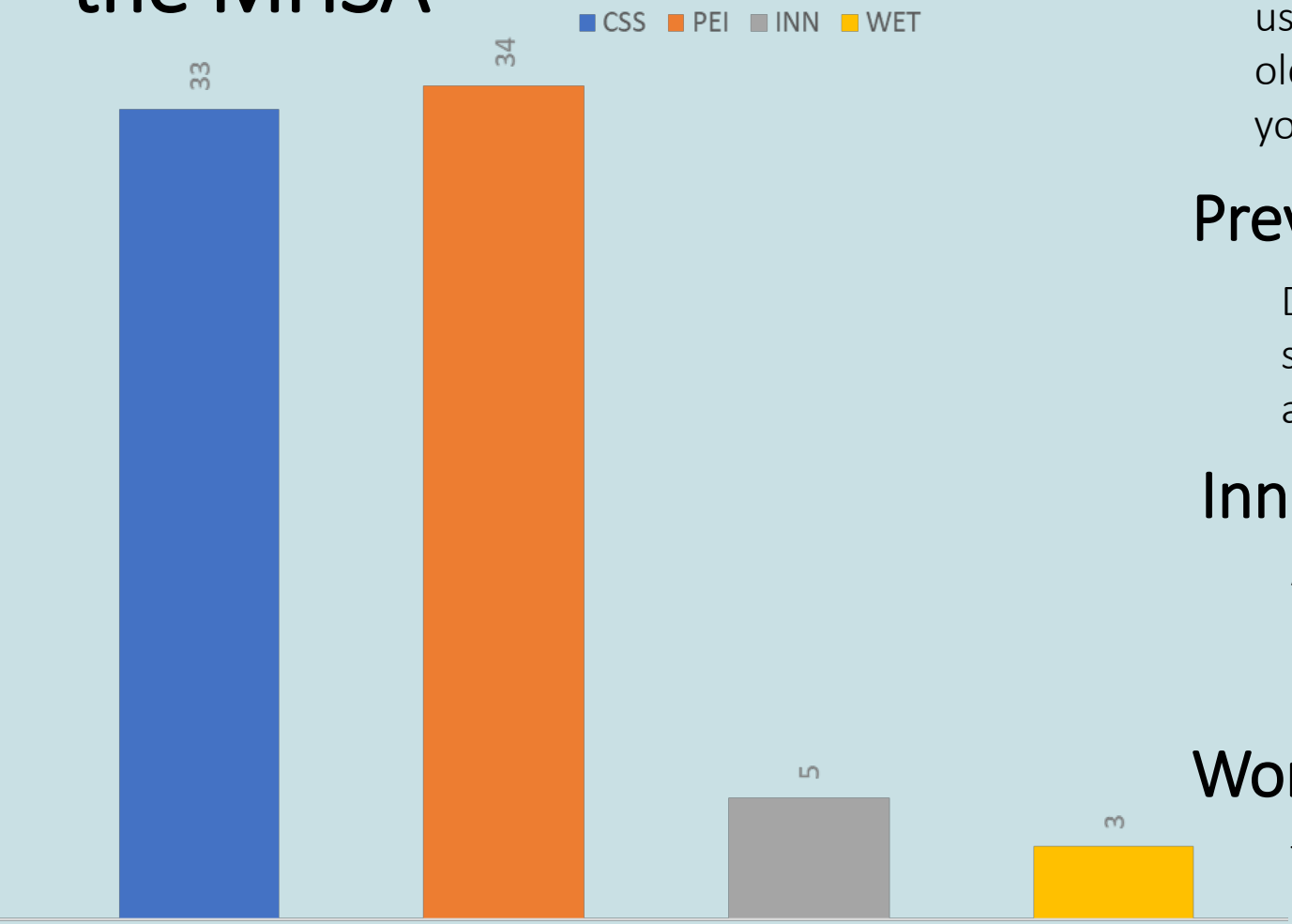
Catalyst Center

How do the proposed BHSA funding allocations differ from existing MHSA funding allocations?





Programs Funded by the MHSA



Summary of CA Alliance Member Survey on the Mental Health Services Act, May 2023

The California Alliance of Child and Family Services surveyed 64 agencies across 24 counties who provide services through programs that are funded by the Mental Health Services Act (MHSA).

Community Services and Supports (CSS)

The largest component of the MHSA. This funding is used to provide essential direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbances.

Prevention and Early Intervention (PEI)

Designed to prevent mental illnesses from becoming severe and disabling, this program enhances timely access to services for underserved communities.

Innovation (INN)

Allows agencies to implement novel approaches in the mental health system that strengthen community collaboration to increase the quality of services.

Workforce Education and Training (WET)

These programs address the ongoing behavioral health professional shortage and in growing the workforce, help expand services to underserved communities.

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Populations Served Through MHSA

Services provided by the MHSA cater to children, transition age youth, adults, older adults, and families.

Program/Service	Populations Served	% of Surveyed Agencies Providing Services
Full Service Partnerships	Children, Transitional Age Youth, Adults and Older Adults	33%
Transitional Age Youth Services	Transitional Age Youth 16–25-year-olds	33%
Outpatient Care Services	Children, Transitional Age Youth, Adults and Older Adults	27%
School Linked Services / School-Based Behavioral Health	K-12 aged children	19%
Crisis Support Teams	ALL	13%
Housing Support	TAY, Adults, Families	9%

The 64 agencies who provide services through programs that are funded by the Mental Health Services Act (MHSA) are currently serving over 67,000 people in California.

Summary of CA Alliance Member Survey on the Mental Health Services Act, May 2023

California Alliance
Empowering lives. Enriching futures.

Types of Programs and Services Funded

- Family Resource Centers
- Outreach services
- Early Childhood Mental Health Consultation
- Special Populations – LGBTQ drop in center; high school mentoring programs
- Family Search and Engagement
- Non-traditional services for Transition Aged Youth
- Undocumented youth services

Questions and Answers from Children and Youth Advocates and Providers

How does SB 326, the Governor's proposal to change the Mental Health Services Act (Proposition 63), deprioritize kids?

- *Under current language, SB 326 (Eggman) allows counties to choose how they spend their categorical funding, giving them the option not to spend anything on children and youth. However, counties are not afforded that same option to refuse to spend money on homelessness. Children and youth should receive the same protections.*

How much funding for children and youth is at risk?

- *In years of high income for California's millionaires, we believe counties spend between $700 million and $1 billion, annually, on the categories of prevention and early intervention, community support and services and full-service partnerships for the benefit of children and youth.*

Questions and Answers from Children and Youth Advocates and Providers

Aren't the recent California Advancing and Innovating Medi-Cal (CalAIM) and the Children and Youth Behavioral Health Initiative (CYBHI) investments enough for children and youth?

- *No. Both CalAIM and the CYBHI have yet to be fully implemented and the majority of the CYBHI is onetime funding. It is premature to reroute funds from the MHSA due to the introduction of CalAIM and the CYBHI when we have yet to fully realize and understand the impact of these investments.*

What kinds of programs are at risk if children's services are not protected?

- *Several programs are at risk, including but not limited to: infant and early childhood mental health consultation, unaccompanied minor youth programs, and school based/linked behavioral health services and supports.*

What would make the proposal stronger for kids?

- We recommend the Legislature set aside funds for children and youth ages 0-25 in every category of MHSA funding: housing, Full-service Partnerships, Prevention and Behavioral Health Services and Supports. This is the only way that we can be sure children and youth are prioritized.

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MHSA "Modernization"

Threat to Community-Defined Evidence-Based Practices & Peer Support Programs

Andrea Wagner

Executive Director

California Association of Mental Health Peer Run Organizations

Outline:

- PEI and INN - essential to MHSA
- Consumer Priorities
- Programs(and people) most affected
- Biggest Concerns

PEI & INN MATTER

MENTAL HEALTH SERVICES ACT
PROPOSITION
63
CALIFORNIA


ONFERENCE ACCESS
Find Your Legislator
BROAD ROOM

LEAD

LIVED EXPERIENCE • ADVOCACY • DIVERSITY

Mental Health Consumers
Across California
Speak Out

Three Years:

65
Listening Sessions

20
County Summits

3 State Conferences













2,657 People

What People Prioritized:

What People Prioritized:

- Eliminating Stigma
- Basic Needs – Showers, food, clothing
- Crisis & Law Enforcement Education and Response
- Increased Services, with Peer Support and Peer Respites
- Youth and Older Adults

“...I think the system is infected with this idea that only professionals can build a fate when there’s a lot of people that are not professionals that can help...”

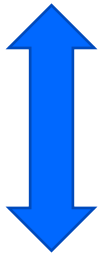
Mental Health Consumer

LEAD Listening Session

Sacramento County 2022

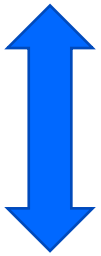
Biggest Concerns

Diverting funding will **kill** many irreplaceable services.



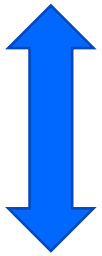
Reducing or Eliminating PEI & INN

"Meet people where they are" services will be pushed out of MHSA funding.



MHSA DollarsTied to Only Medi-Cal Billable Services

All stakeholders – will lose their voice in mental health planning.



Reducing or Eliminating Community Planning Process

MHSA Modernization?

Wellness, Recovery, and Resilience Focused

Community Collaboration

Client Driven

Cultural Competence

Integrated Service Experience

Family Driven

This IS MHSA Elimination

Thank you

Andrea Wagner

andrea@camhpro.org

www.camhpro.org

LAO

Mental Health Services Act: Governor's Behavioral Health Modernization Proposal

July 13, 2023

Our office has published a series of posts analyzing the Governor's Behavioral Health Modernization proposal. We plan to continue to publish posts over the coming weeks analyzing other components of the proposal and will send out an announcement along with key takeaways from each piece.

Mental Health Services Act: Revenue Volatility and the Governor's Proposal to Reduce Allowable County Reserves

Key Takeaways

- ***Recommend Rejection of Governor's Proposal to Reduce Allowable County Reserves***. In light of extreme Mental Health Services Act (MHSA) revenue volatility, allowable county reserves would have to be around two-thirds higher than their current levels to provide reasonable protection against declines in revenue. The Governor's proposal would therefore move allowable reserves in the wrong direction. In addition, we think counties should generally have more flexibility in how they can deposit and use reserves and offer suggestions for how to improve the overall MHSA reserve policy.

- ***Recommend Addressing MHSA Revenue Volatility Head On.*** The volatile MHSA tax is not suited to supporting ongoing mental health services and sufficiently mitigating MHSA revenue volatility with a reserve policy alone would be challenging. A more straightforward approach would be to change the MHSA revenue source. We offer an option that we think has little downside from either the state's or counties' perspectives.

LAO Contact: Ryan Miller

Mental Health Services Act: Proposed Restructuring of the MHSA Funding Categories and Impacts on County Spending

Key Takeaway

- ***Administration's Justification of Proposed Changes Incomplete.*** The administration's proposal would reduce county spending flexibility and shift the focus of MHSA funding to Full-Service Partnerships and housing interventions. We find that the proposal likely will result in counties spending less on a number of current programs funded through MHSA, potentially reducing outpatient services, crisis response, prevention services, and outreach. We find that the administration's justification for the proposal is incomplete and we provide several questions for the Legislature to ask the administration to assess whether the proposal is warranted. For example, can the administration provide evidence that the proposal is likely to result in better behavioral health outcomes for the population as a whole?

LAO Contact: Will Owens

Mental Health Services Act: Proposed Change in Mental Health Services Oversight and Accountability Commission's Role

Key Takeaway

- ***Recommend Maintaining Mental Health Services Oversight and Accountability Commission's Authority Absent Compelling Justification for Governor's Proposal.*** While the commission would continue to serve in an advisory role to the administration and the Legislature under the Governor's proposal, the Governor proposes to remove most of the commission's current oversight, regulatory, and programmatic authority over MHSA funding. We find that the proposed substantial reduction of the commission's authority would limit its independence. Given the lack of analysis provided by the administration on the potential benefits of its proposal, we recommend the Legislature consider maintaining the commission's current roles in providing general oversight as well as implementing certain components of the MHSA. Additionally, we recommend maintaining the commission's authority to receive all information requested of state departments and all state and local entities that receive MHSA funding at its independent discretion.

LAO Contacts: Ryan Miller, Will Owens

Why Meaningful Community Engagement Matters & Best Practices

MHSOAC Community Engagement

Sergio Aguilar-Gaxiola, MD, PhD
Professor of Clinical Internal Medicine
Director, Center for Reducing Health Disparities
Director, Community Engagement Program of the Clinical and Translational Science Center
UC Davis School of Medicine

July 27, 2023

UCDAVIS HEALTH | Center for Reducing Health Disparities

UCDAVIS HEALTH | Clinical and Translational Science Center

The Bottom Line

Improving the health/mental health of all our communities through reducing health disparities

A critical ingredient:

Community Engagement

"Authentic and sustainable community engagement is **integral to advancing health equity and eradicating barriers to community well-being**."

Urban Institute, 2021

Community Engagement Defined

"Community engagement is an ongoing, evolving process of **multidirectional communication** with and for people to solve the problems and **address the concerns that matter to them**. **The process should be durable, long-lasting, and equitable to all who participate**. The ultimate goal is to **learn, implement and disseminate the practices of equitable partnering, influence policies, programs, and practices for the betterment of the community**."

Principles of Community Engagement, 3rd edition: Chapter 1

Community Engagement has Become a “Hot” Topic

NEJM Catalyst | Innovations in Care Delivery

ARTICLE

How Hospitals Improve Health Equity Through Community-Centered Innovation

Leonard L. Berry, PhD, MBA, Sunjay Letchuman, Joneigh Khaldun, MD, MPH, FACEP, Michael K. Hole, MD, MBA

Vol. 4 No. 4 | April 2023

DOI: 10.1056/CAT.22.0329

March 23, 2023

CELEBRATING 30 YEARS

Healthforce Center at UCSF

A Collective Force for Health, Equity, and Action

NETWORK HIGHLIGHT

Healthforce Center Pursues Expansive Vision of Health with Community Partnerships

Community-Based Organizations to Join Reimagined California Improvement Network

Date: January 11, 2023

By Kathryn E. Phillips, Associate Director, California Health Care Foundation

Mental Health Services Act (MHSA)

- “Increase the number of PEI programs and systems, including those utilizing community-defined practices, that **focus on reducing disparities for unserved, underserved, and inappropriately served racial, ethnic, and cultural communities**.” P.12

- **Community-driven initiative and service delivery design to reach traditionally underserved populations**

- **Required a community planning process**

https://mhsoac.ca.gov/wp-content/uploads/MHSA-Jan2020_0.pdf

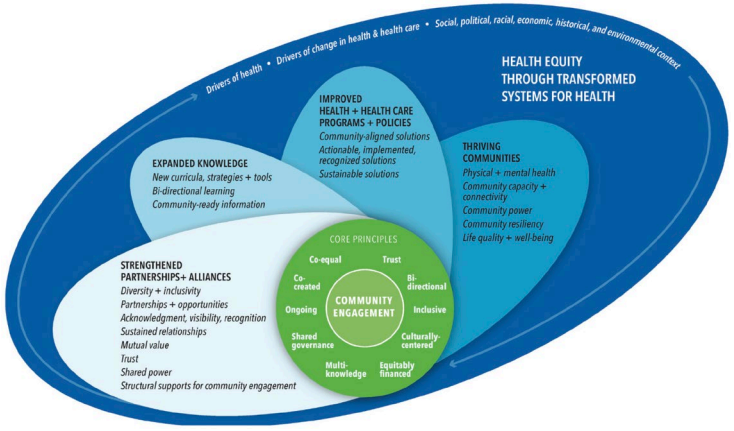
Community Engagement Best Practices

1. ICCTM Model and Learning Collaborative

SOLANO COUNTY INTERDISCIPLINARY COLLABORATION AND CULTURAL TRANSFORMATION MODEL (ICCTM) INNOVATION PROJECT: FINAL EVALUATION REPORT

2. Principles of Community Engagement 3rd Ed.

3. NAM Assessing Meaningful Community Engagement in Health and Health Care



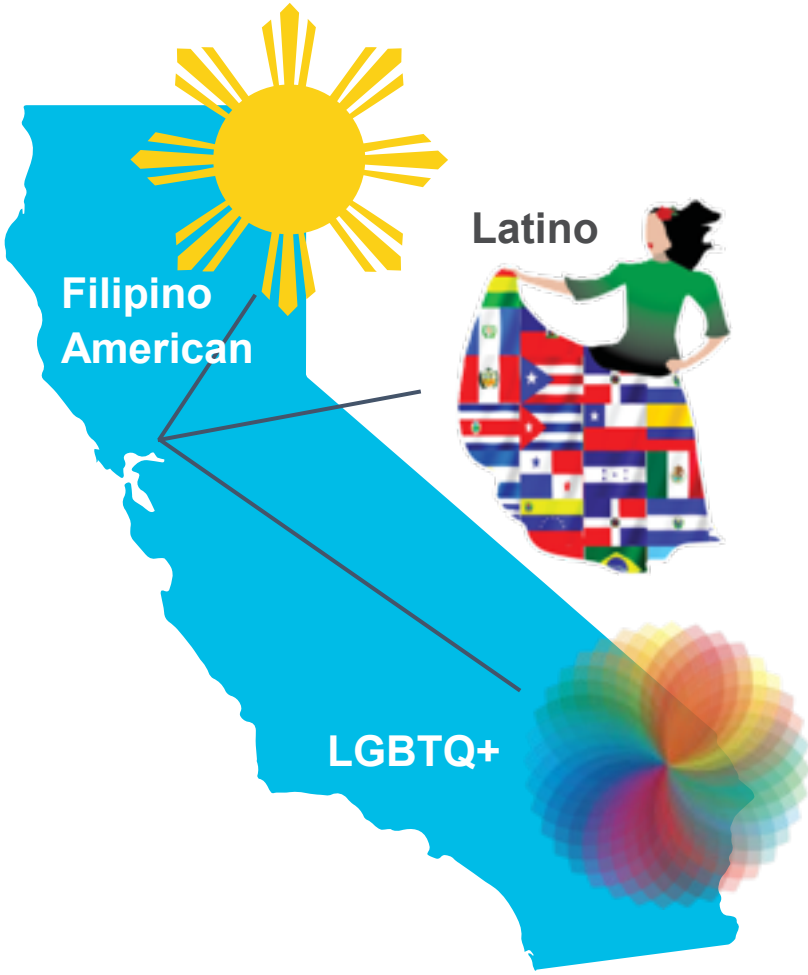
Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)

2016 - 2021

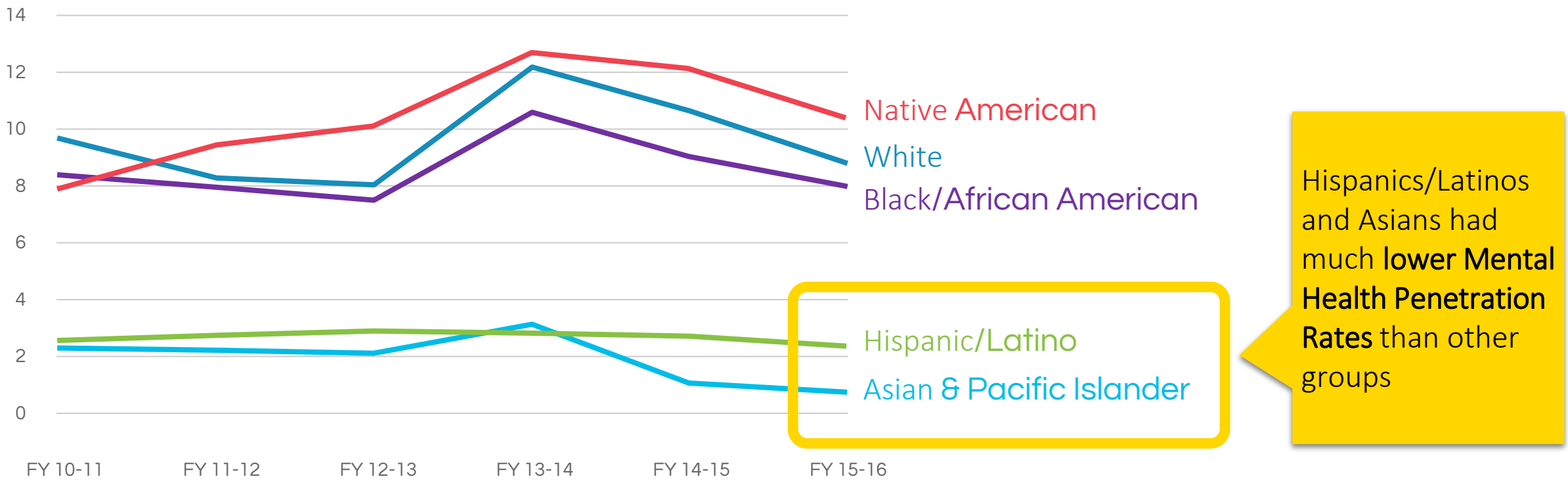
5

YEARS

- 5-year multi-phase **Mental Health Services Act (MHSA) Innovation Project**
- Focused on **three priority underserved populations in Solano County**
- Anchored in the nationally recognized **Culturally and Linguistically Appropriate Services (CLAS) Standards**
- First project that combines **CLAS** and **community engagement**



Solano County Mental Health Plan Service Penetration Rates by Race/Ethnic Group

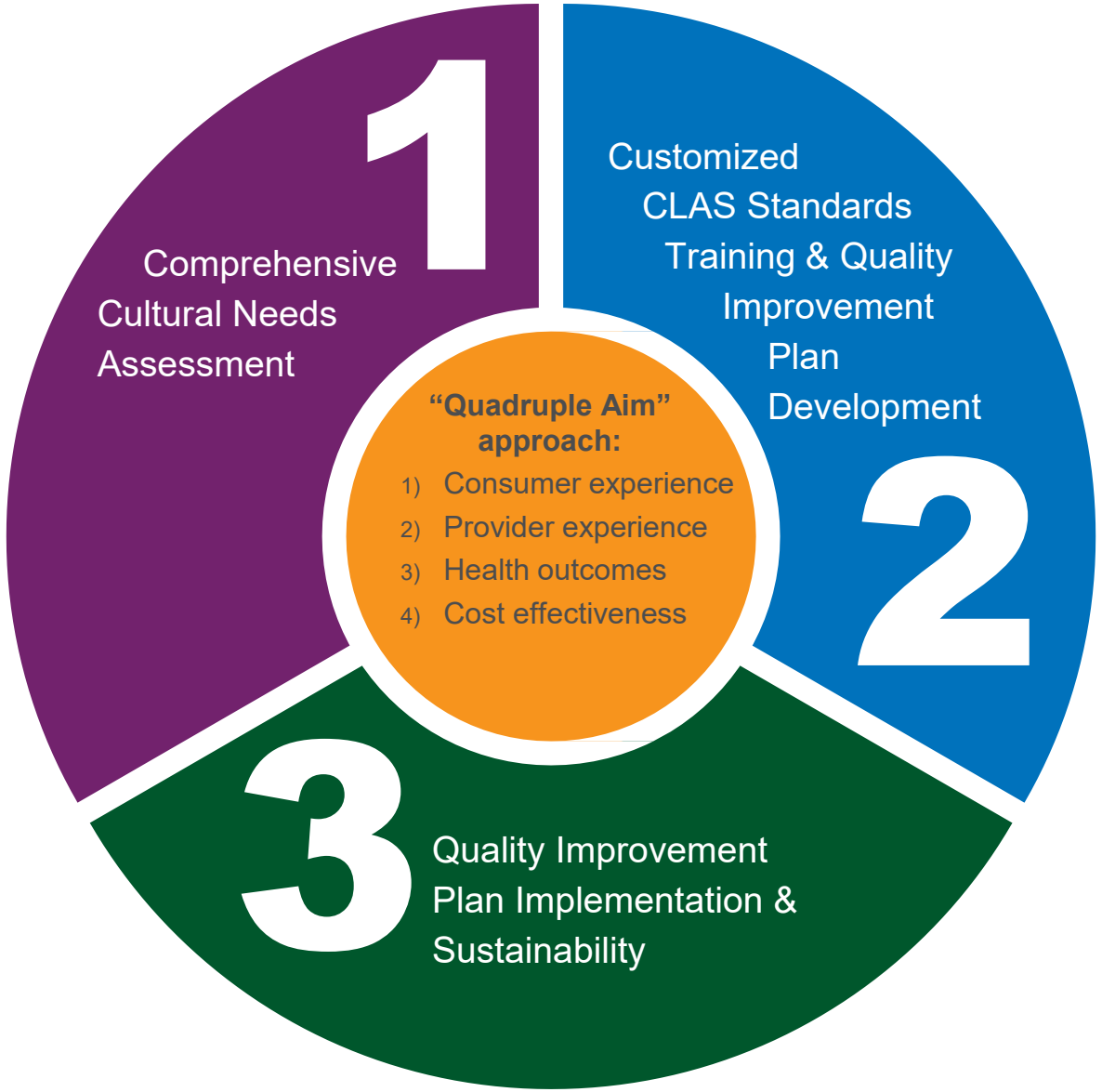


Note: Penetration rates are calculated by dividing the number of Medi-Cal beneficiaries receiving mental health services by the number of Medi-Cal eligible beneficiaries

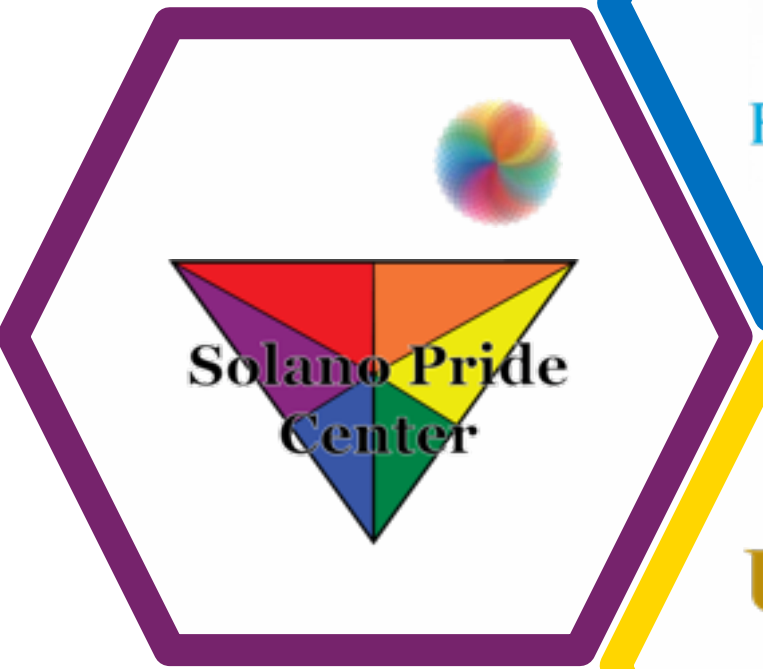
Source: External Quality Review Organization (EQRO) and Solano County Behavioral Health

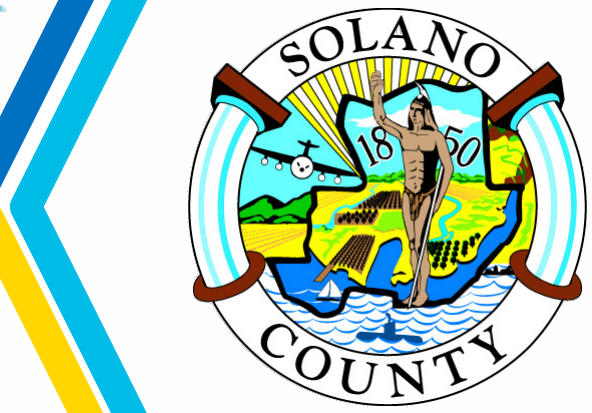
ICCTM Community Engagement

1. **Comprehensive health assessment** with the three populations of focus.
2. **Development and facilitation of a Solano-specific CLAS training** for cross-sector participants representing the community
3. **Development of Culturally and linguistically relevant quality improvement (QI) action plans** designed to improve mental health service delivery



ICCTM Partners





UCDAVIS HEALTH

Center for Reducing Health Disparities

Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Outcomes

- Improved engagement and calls to the access lines
- Decreased first admissions via crisis services and increased outpatient services

ICCTM Outcomes

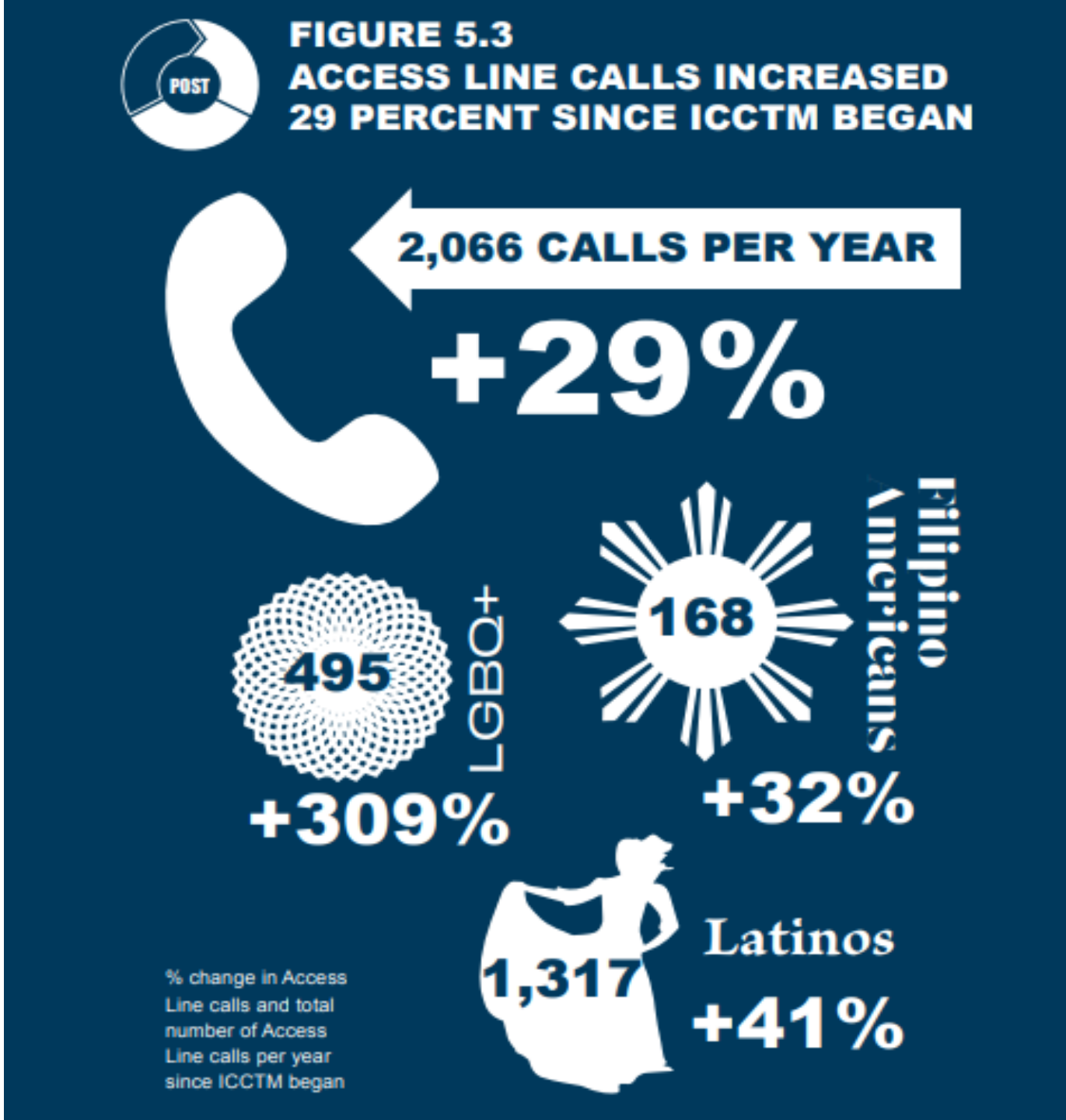
Improvement in Intake Assessment Offered within 10 Days

+9%

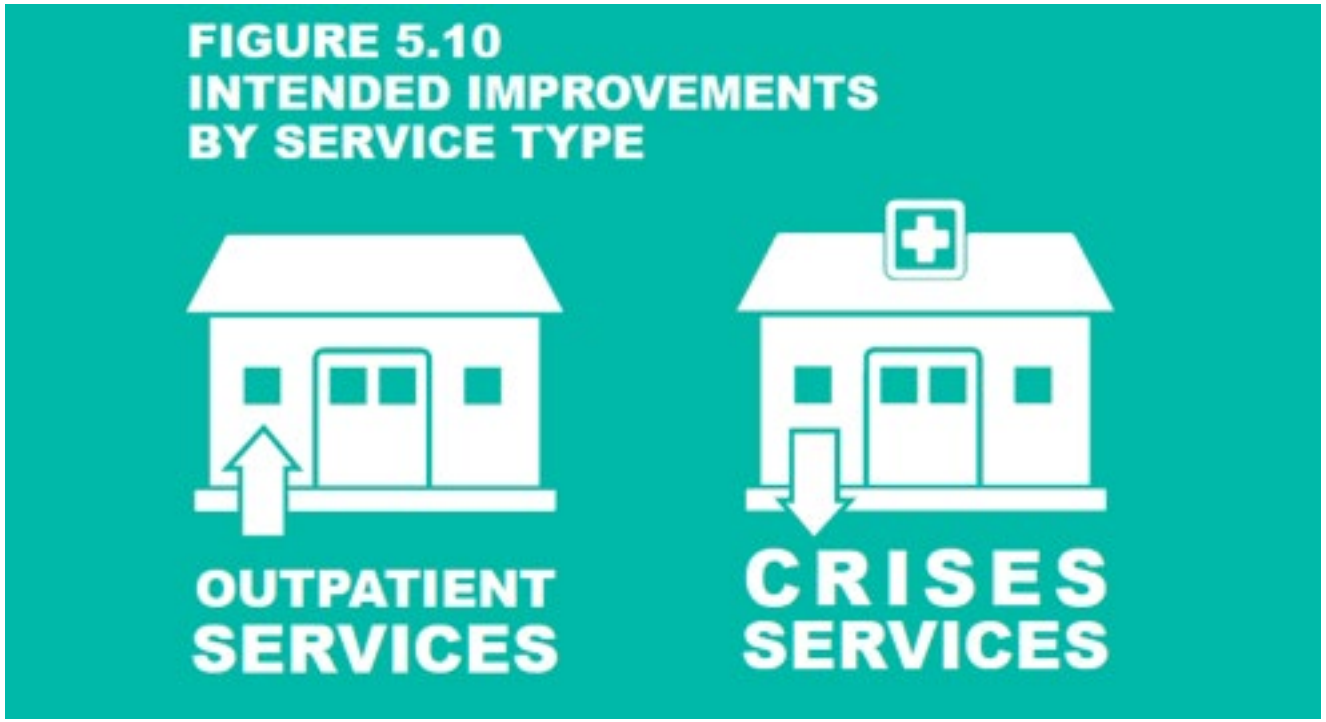
+32%

+4%

Source: Center for Reducing Health Disparities – Solano County ICCTM Innovation Project Final Evaluation Report: https://health.ucdavis.edu/media-resources/crhd/documents/pdfs/icctm-final-report-2021-09-13.pdf



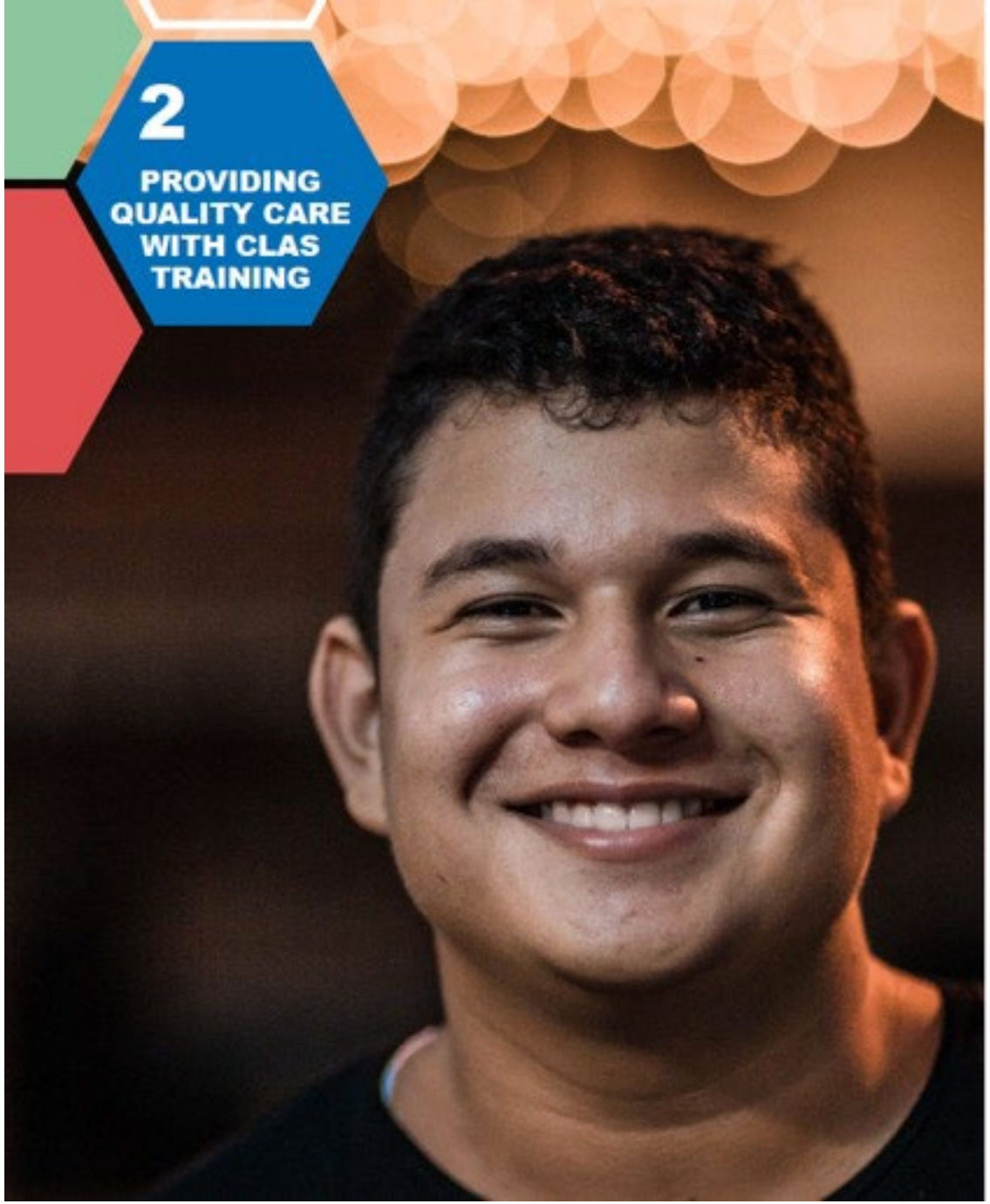
ICCTM Outcomes



- These trends reflected **increased trust towards primary mental health care providers in Solano County** and **resulted in substantial cost savings**

SOLANO COUNTY INTERDISCIPLINARY COLLABORATION AND CULTURAL TRANSFORMATION MODEL (ICCTM) INNOVATION PROJECT: FINAL EVALUATION REPORT

JUNE 2021



https://health.ucdavis.edu/media-resources/crhd/documents/pdfs/icctm-final-report-2021-09-13.pdf

ICCTM Learning Collaborative Training Topics

Practice & Support

Between community engagement sessions, counties will be able to practice skills with local communities

Learning Collaborative training series open to all CA counties and cities receiving MHSA funding

2 training cohorts

Mentor–Mentee Component
4 Mentee Counties

1. Overview of the Solano County ICCTM Project
2. The Impact of COVID on Mental Health
3. Social Determinants of Health
4. National CLAS Standards
5. Trauma in the Trenches
6. Untangling Intangible Loss in the Treatment of Traumatic Grief
7. Quality Improvement & Mental Health Equity Data

8 -10. **Community Engagement Models** (3 sessions)

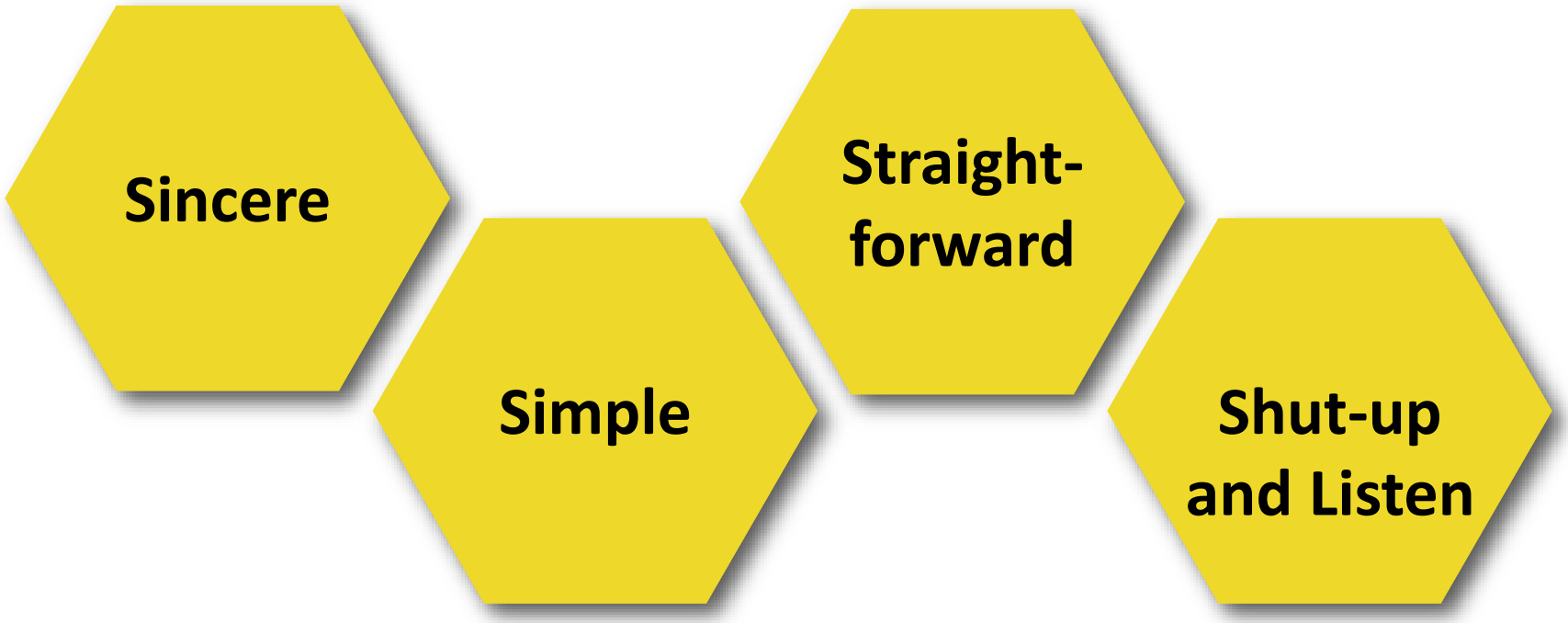
11. ICCTM Sustainability

Lessons Learned in Building Effective Community Partnerships

- **Multistakeholder community partnerships are required**
- **Use a health equity lens**
- **Listen attentively to all** and **treat partners with dignity and respect**
- **Review local data** on mental health outcomes in local communities, connect dots, and look for what is missing
- **Actively** look for community assets, strengths and resilience and use them
- **Design and implement for sustainability** right from the go
- **Start** – don't over plan – learn and adapt as you go
- **Building trust and becoming a trustworthy organization are front and center**

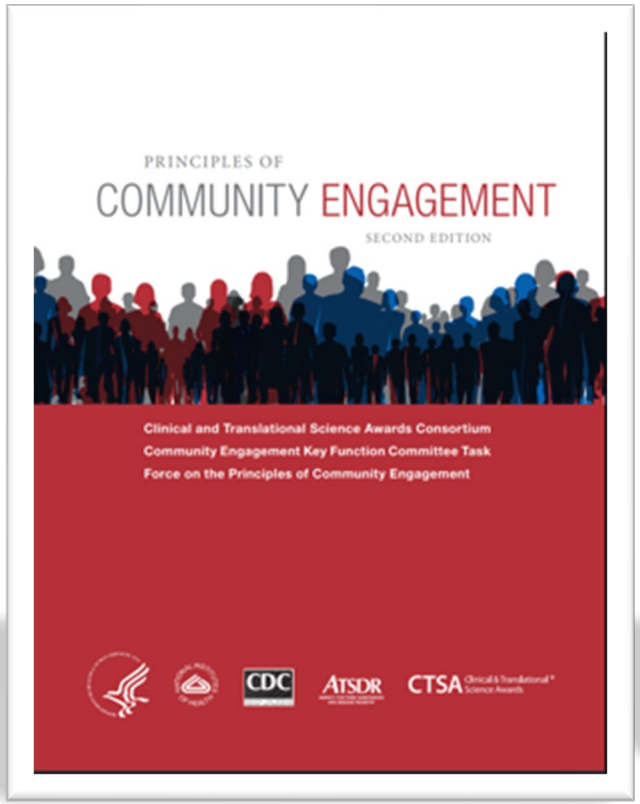
Adapted from Michener, 2022

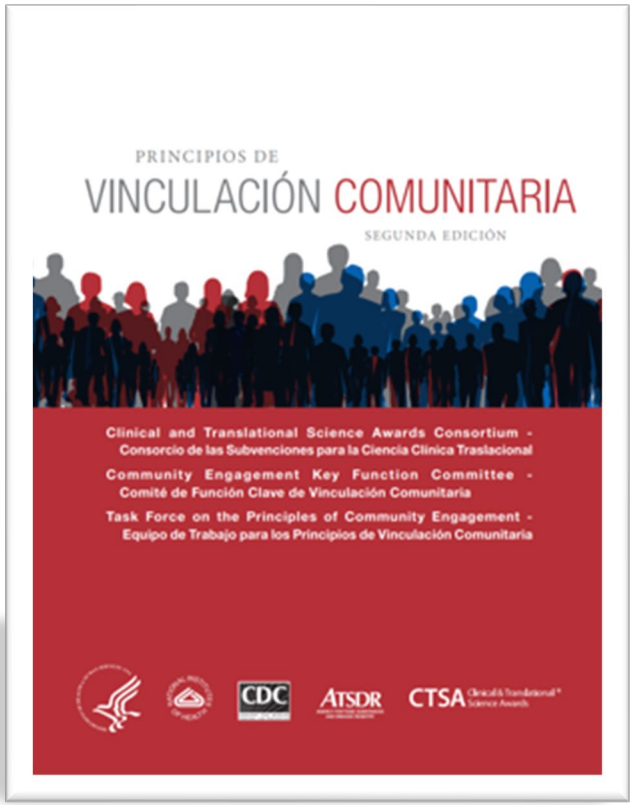
Main Lessons Learned…4 Ss



How do you do meaningful community-engaged work?

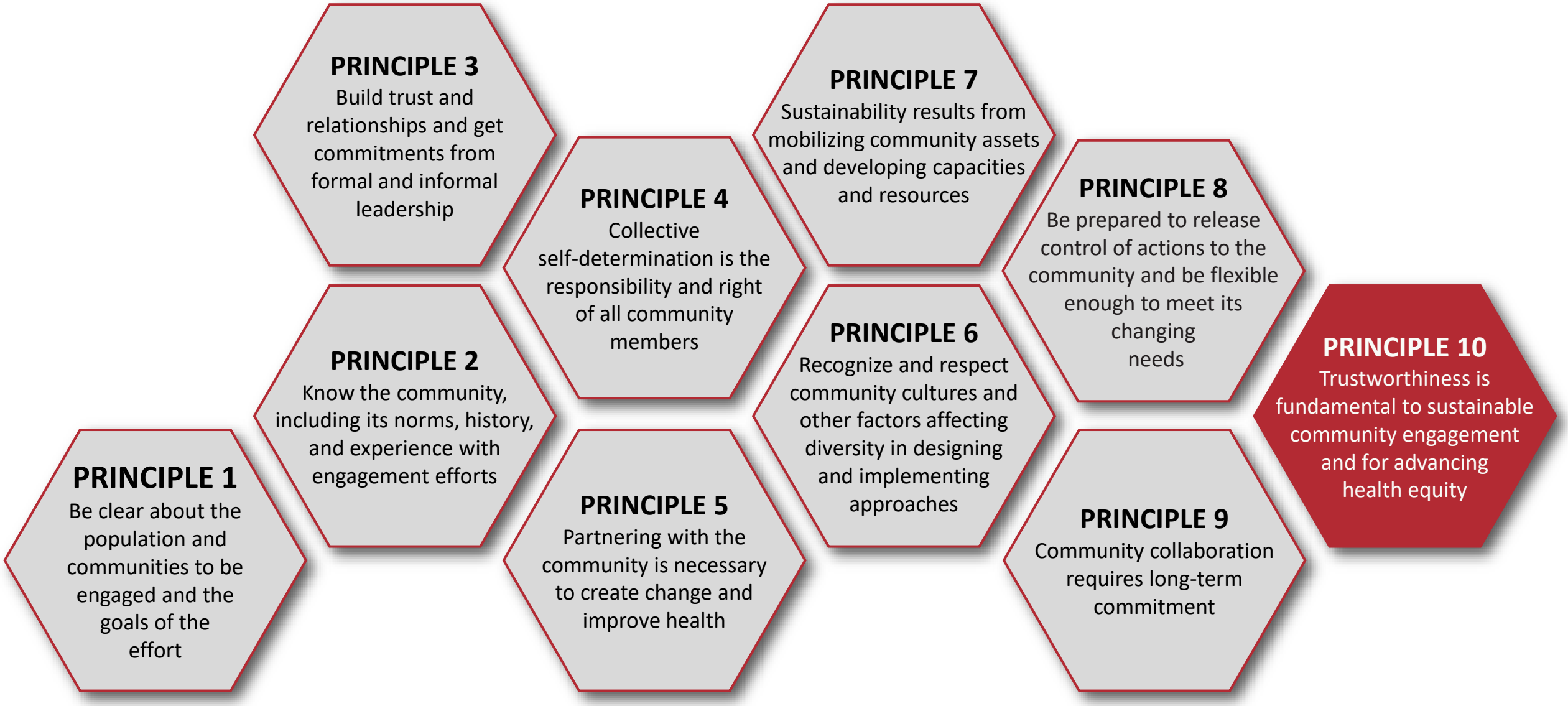
Follow the Principles of Community Engagement





Online English and Spanish:
http://www.atsdr.cdc.gov/communityengagement

Principles of Community Engagement 3rd. Ed.

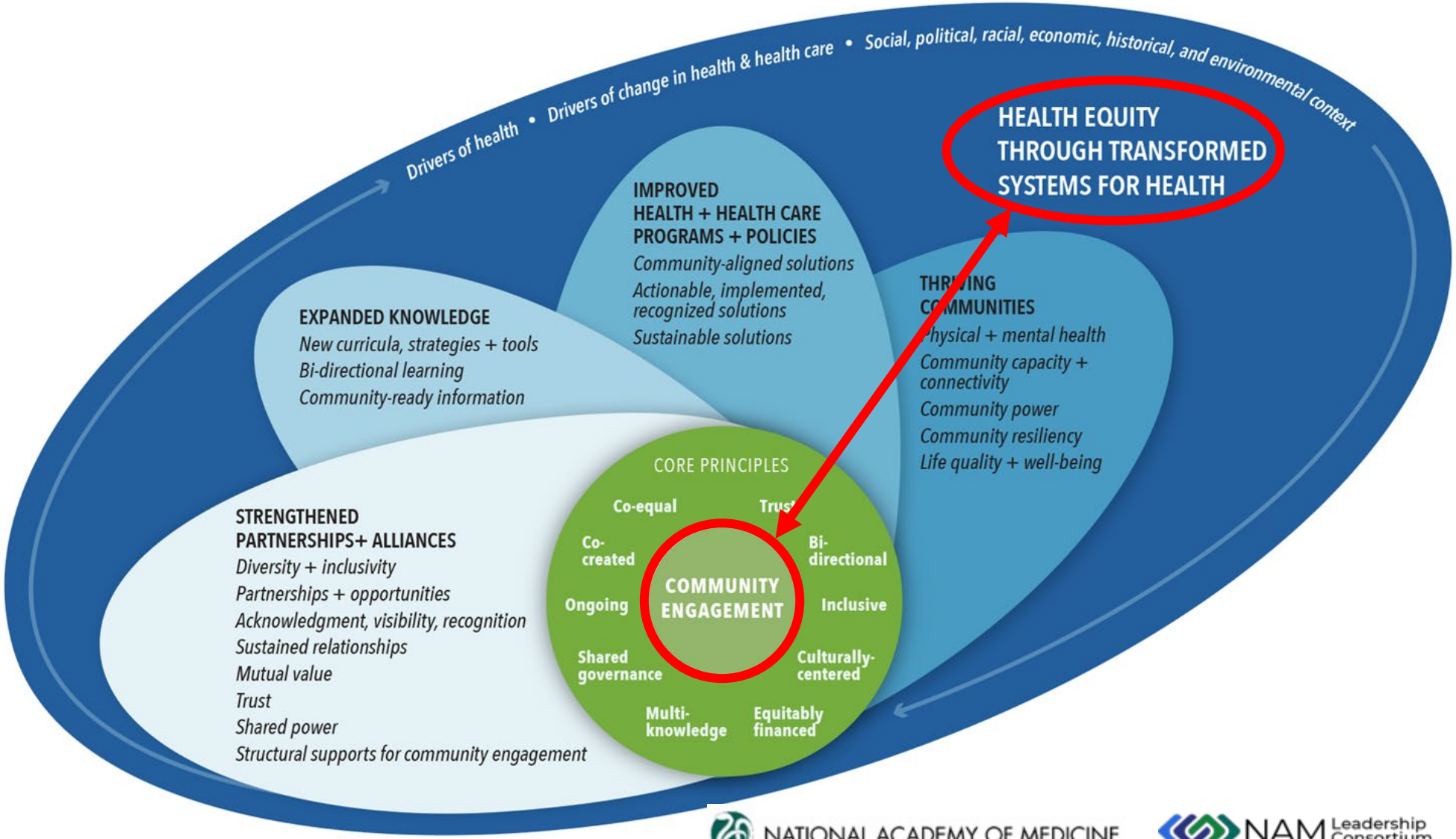


Principle 10

- Trustworthiness is essential to forming effective partnerships and, over time, will deepen commitment **through building relationships based on empathy, honesty, respect, and humility**
- Partnerships built around deliberative means of engagement and **bidirectional communication** are required for trustworthiness
- **Listening attentively to what matters to communities is absolutely necessary**

Wilkins, 2018; Cheung, 2018

Advancing Health Equity and Systems Transformation through Community Engagement



SCAN ME

NATIONAL ACADEMY OF MEDICINE

NAM Leadership Consortium
Collaboration for a Learning Health System

Trust is a Core Component of Engagement

- **It requires:**
  - **showing up authentically, being honest, following through on commitments, and committing to transparency in order to build a long-lasting and robust relationship**
  - **change on the part of all partners**
  - **that entities engaging communities commit themselves to being trustworthy**
- A foundational component of building trust with communities is **demonstrating that community trust is warranted and will not be abused or exploited**

https://nam.edu/programs/value-science-driven-health-care/assessing-meaningful-community-engagement/

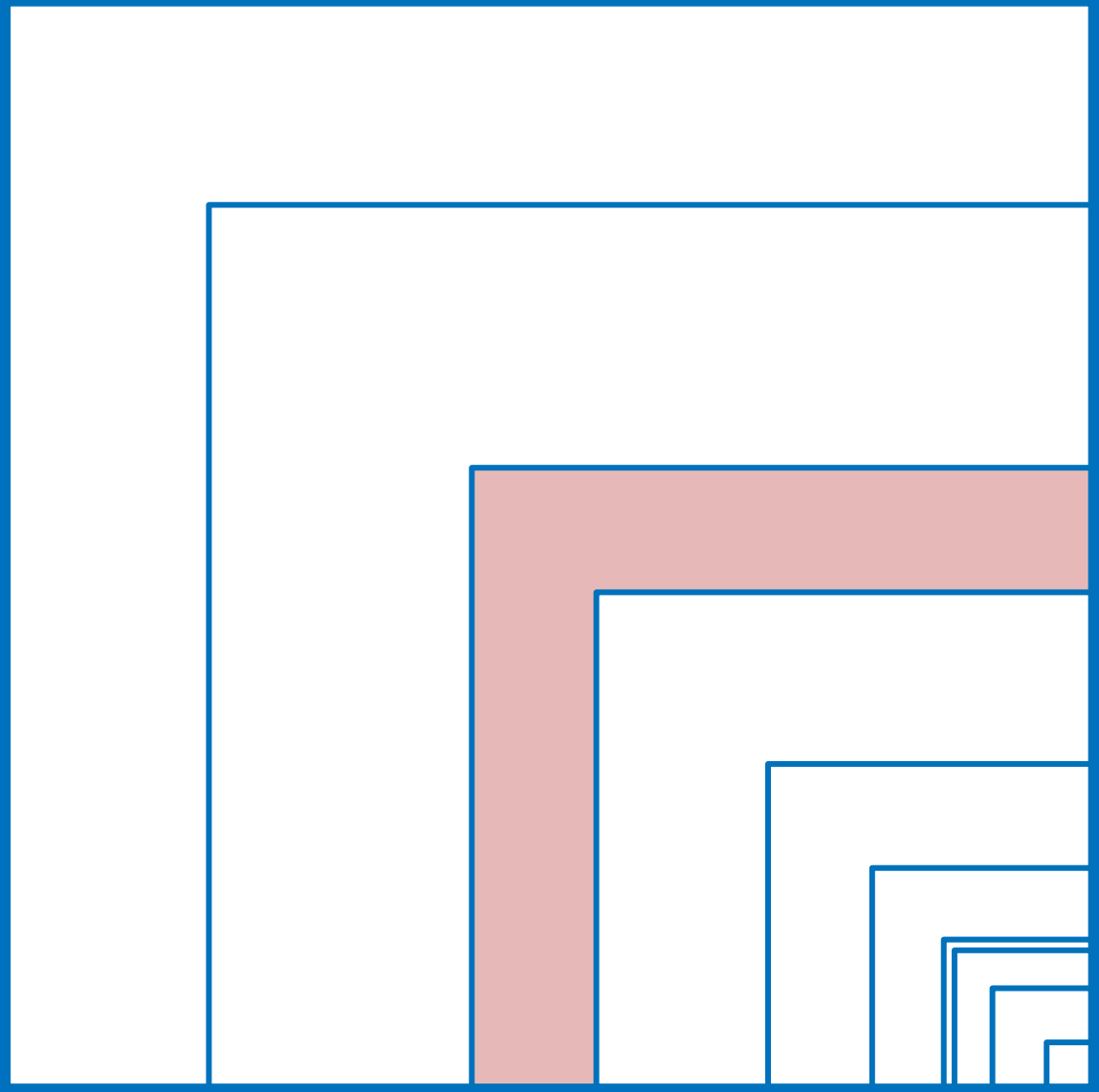
Innovative Models of Mental Health Service Delivery are Needed for Underserved Populations

Health and mental health inequities for historically underserved populations including immigrants have persisted for decades

Inequities have been particularly exacerbated during the COVID pandemic

New models of service delivery are much needed to effectively increase access to care and utilization of services where people live, work, and congregate in order to advance health equity

The "Ecology" of Medical Care - Revisited



Green LA, et al., New England Journal of Medicine, 2001;344:2021-5.

The prevailing model of health care service delivery has been the "Waiting Mode" (Come to Us)

1,000 people

800 report symptoms

327 consider seeking medical care

217 visit a physician's office (113 for primary care)

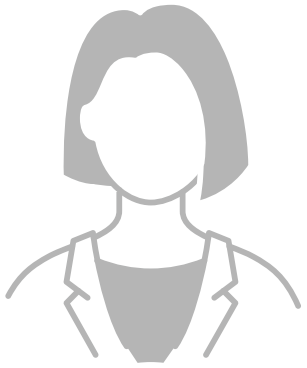
Many people left with unmet health needs

65 visit a complementary or alternative medical provider

21 Visit a hospital outpatient clinic
14 receive home health care
13 visit an emergency department
8 are hospitalized

<1 is hospitalized in an academic medical center

A Paradigm Shift is Needed



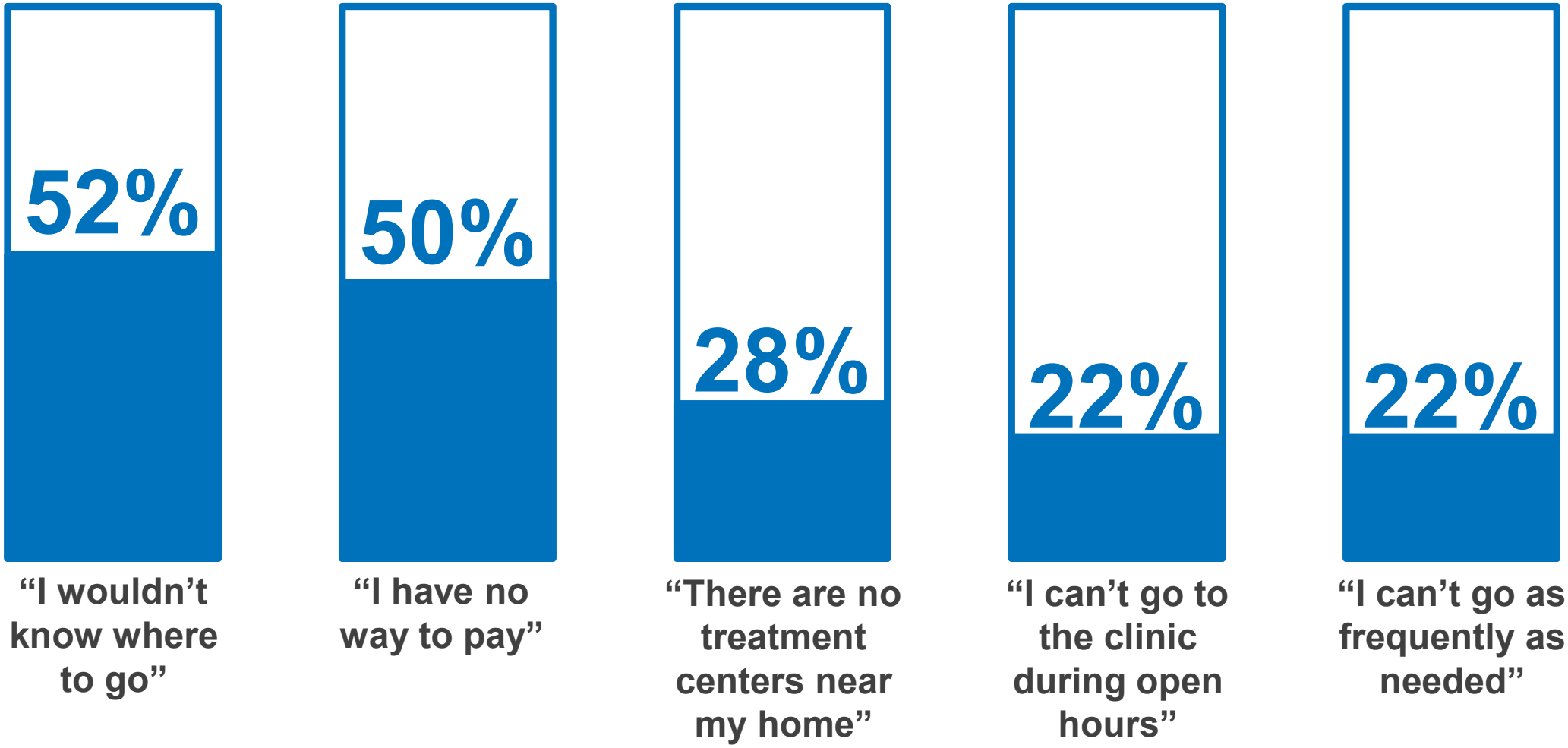
“Waiting Mode”
Waiting for those in need to come for services

Treat conditions when symptoms are set, complications ensue and normal function is lost

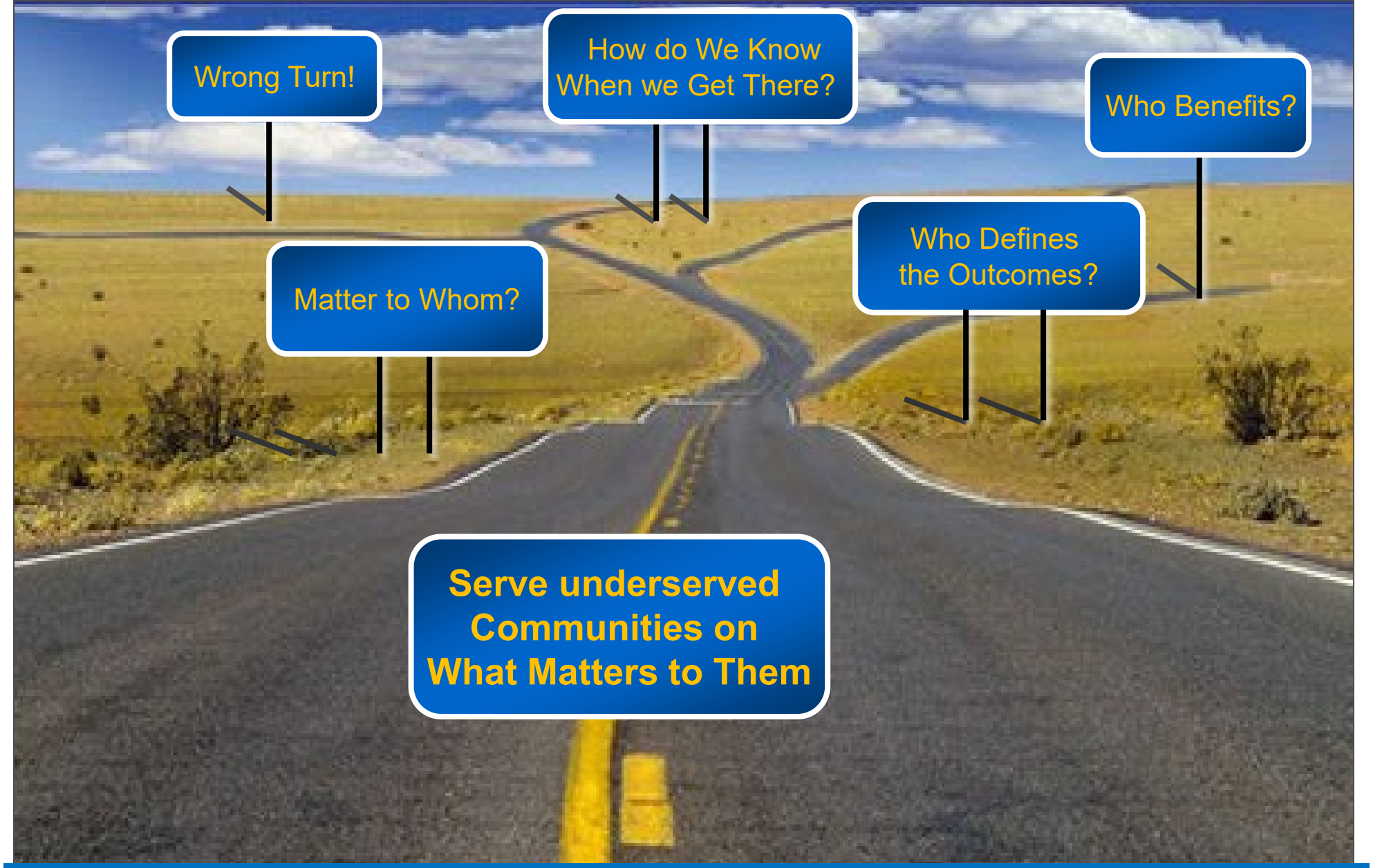
“Seeking Mode”
We need to go to them

Intervene before symptoms appear or when they start and preserve normal function for as long as possible

Institutional Barriers



“Mexican American Prevalence and Services Survey” (MAPSS 2000) study of 4,013 rural and urban Mexican American and Mexican origin adults



The Road(s) Ahead: Outcomes that Matter

Recommendations

1. **Put community engagement (CE) in "the water"** of what the MHSOAC does in collaboration with its partners. It will necessitate an organizational cultural change (e.g., include CE in the OAC Strategic Planning Process, be guided by CE best practices, etc.)

2. **Take the lead and become a model agency on CE** and advocate that every state agency should have an established community engagement plan as part of their strategic plan (i.e., **lead a paradigmatic shift to incorporate the "Seeking Mode" and go where people are at**)

3. **Sponsor legislation to fortify community engagement** across all state agencies

4. **Advocate for the state to fund community engagement** at a level on par with the disparities that need to be addressed

5. Advocate for **the inclusion of meaningful community engagement** in the Modernization Act

6. **Provide training on community engagement best practices** to various stakeholders and how to successfully do community engagement with accountability (i.e., outcomes and impact)

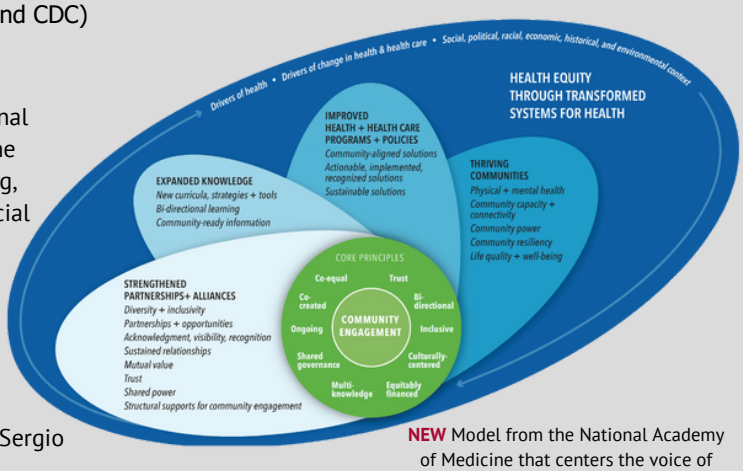
7. **Continue to support** the statewide Learning Collaborative training counties

PRINCIPLES OF
COMMUNITY ENGAGEMENT
3RD EDITION

1 Chapter 1: Community Engagement: Definitions and Organizing Concepts

Linda B. Cottler, Christopher Holliday, Christine Prue, Donna Jo McCloskey, Mary Anne McDonald, Irvin Pedro Cohen,Sergio Aguilar-Gaxiola, Milton "Mickey" Eder (NIH and CDC)

NEW DEFINITION OF ENGAGEMENT:
Community engagement is an ongoing, evolving process of multidirectional communication with and for people to solve the problems and address the concerns that matter to them. The process should be durable, long-lasting, and equitable to all who participate. The ultimate goal is to influence social action, programs, and practices for the betterment of the community.



NEW Model from the National Academy of Medicine that centers the voice of the community.

2 Chapter 2: Principles of Community Engagement

Donna Jo McCloskey, Elizabeth Cohn, Gustavo Loera, Michael T. Hatcher, Sergio Aguilar-Gaxiola

1. Be clear about the purposes or goals of the engagement effort and the populations and/or communities you want to engage.
2. Become knowledgeable about the community's culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history, and experiences with efforts by outside groups. Be aware of each other's perceptions of past engagement activities.
3. Build and maintain relationships and trust by working with individuals and/or community leaders.
4. Remember and accept that collective self-determination is the responsibility and right of all people in a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.
5. Establish a partnership with the community to create change and improve health.
6. Recognize and respect the diversity within the community.
7. Identify and mobilize community assets and strengths through developing the community's capacity and resources to make decisions and take action.
8. Recognize that individuals and institutions must be prepared to release control and be sufficiently flexible to meet changing needs.
9. Foster community collaboration and strengthen long-term commitment among the partners.
NEW 10. Demonstrating trustworthiness is fundamental to sustaining successful community engagement and to advancing diversity, equity, and inclusion.

3 Chapter 3: Successful Examples in the Field

Elizabeth Cohn, Donna Jo McCloskey, Tabia Henry Akintobi, Gustavo Loera, Sergio Aguilar-Gaxiola

4 Chapter 4: Building and Strengthening Organizational Capabilities for Community Engagement

Chyke A. Doubeni, Paula L. Bush, Zeno Franco, Syed Ahmed, Suganya Karuppana, Mary Gorfine, Elizabeth Cohn, Jack Westfall, Michael T. Hatcher

PRINCIPLES OF COMMUNITY ENGAGEMENT 3rd Edition

5 Chapter 5: Opportunities for Facilitating Community-Engaged Research

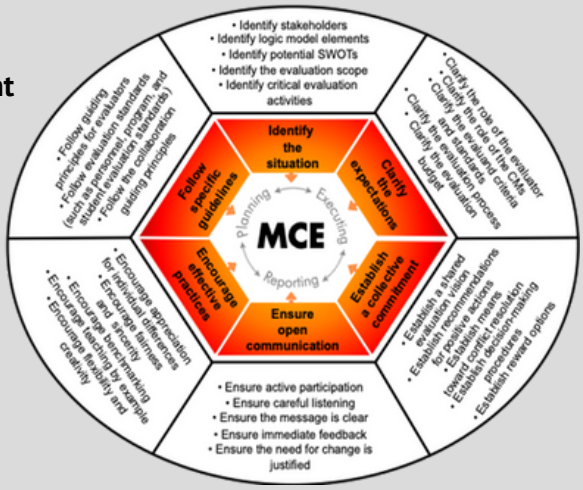
Laurene Tumiel-Berhalter, Olga Brazhnik, Sergio Aguilar-Gaxiola, Arleen Brown, Lori Carter-Edwards, Ahmed Elmi, Laura Sugarwala, Carla Williams, Consuelo Wilkins

6 Chapter 6: Understanding Social Networks in Community Engagement

Mina Silverberg, Ann M. Dozier, Liam O'Fallon, Dixie Duncan, Tiarney Ritchwood, James Dearing, Jehan Benton-Clark, Sergio Aguilar-Gaxiola

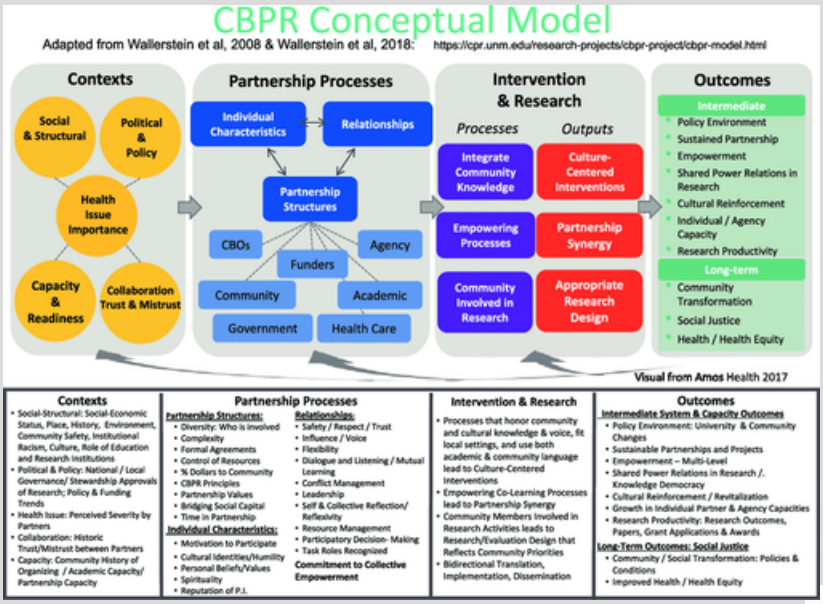
7 Chapter 7: Advancing Equity through Community-Partnered Program Evaluation

Tabia Henry Akintobi, SJ Dodd, Lauren Estby, Latrice Rollins, Thomas C. Cotton III, Shantrice L. Jones, Kimberly N. Harris, Natalie E. Cook, Kendra Piper, Katherine Gower, Ann M. Dozier, Milton "Mickey" Eder



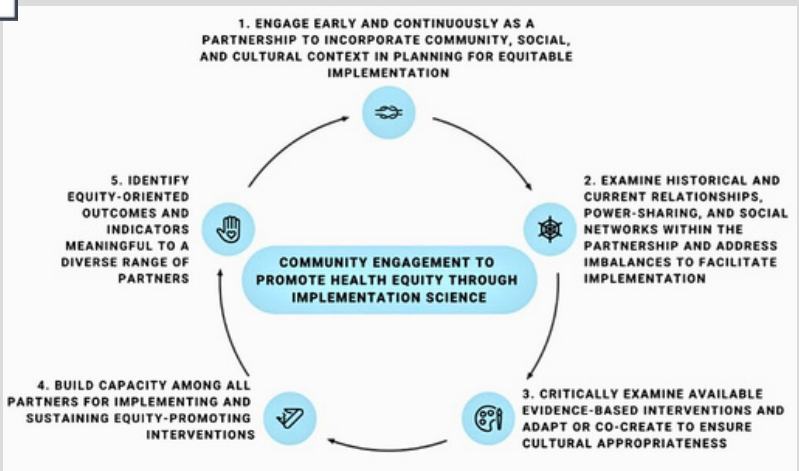
NEW MODEL

Source: "Collaborative Evaluations: Step-by-Step" Second Edition © 2013 by Liliana Rodríguez-Campos & Rigoberto Rincones-Gómez. Published by Stanford University Press. Used with permission of the authors.



8 NEW Chapter 8: Community Engagement Measures and Assessment of Practices with Potential for Success

Nina Wallerstein, Melanie Ward, Blake Boursaw, Milton "Mickey" Eder, Sarah Kastelic, John Oetzel



9 NEW Chapter 9: Community Engagement to Promote Health Equity through Implementation Science

Rachel C. Shelton, Prajakta Adsul, Ana A. Baumann, Shoba Ramanadhan

10 NEW Chapter 10: Sustaining the Engagement: Examples of Environmental Justice Projects

Laurel Berman, Perry H Charley, Lydia Vannessa Frazier, Ken Meter, Jamie Rayman, Neilroy Singer

Assessing Meaningful Community Engagement in Health & Health Care Policies & Programs project

The National Academy of Medicine landmark resources and publications that may be helpful as guides for community engagement work. This includes the Assessing Meaningful Community Engagement (ACE) project resources and Guide to support their implementation, which are linked below.

- ACE Conceptual Model
  Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health

- ACE Impact Stories
  Assessing Meaningful Community Engagement | Impact Stories

  The NAM's Assessing Meaningful Community Engagement in Health & Health Care Policies & Programs project is identifying concepts and metrics that can best assess the extent, process, and impact of community engagement. Centering community engagement can meaningfully advance health equity, transform systems for health, and improve health and well-being for all.

  To provide real-world experiences on the process and outcomes of community engagement, the Project is proud to share seven Impact Stories. Building on the NAM Assessing Community Engagement Conceptual Model, these Impact Stories represent individual perspectives on a snapshot of community engagement efforts across a wide range of engagement levels, communities, geographic locations, and health areas of focus.

  These Impact Stories demonstrate a variety of approaches to the complex process of community engagement and show that it is possible to understand and assess the impact of the engagement on strengthened relationships and alliances, expanded knowledge, improved health and health care programs and policies, and thriving communities – the four domains in the Assessing Community Engagement Conceptual Model, released in 2022.

- ACE Assessment Instrument
  Assessing Meaningful Community Engagement | Assessment Instruments

In order to provide easy access to existing and effective tools that have been used across different contexts and communities to assess engagement, the Project has identified 28 Assessment Instruments, each providing standard questions or question sets to assess engagement in a consistent and rigorous manner. These Instruments and the questions have been mapped onto the Project's Conceptual Model.

These Instruments can help stakeholders understand how community engagement efforts are working and how they can improve. In addition, these Instruments can help ensure use of community-inclusive evidence and rigorous measurement to evaluate efforts. For each Assessment Instrument a Summary that includes how the Instrument was developed, how community was engaged in the process, and how the questions align with the Project's Conceptual Model is provided to help users easily find the most relevant tool to advance their goals. Users can explore and sort the Assessment Instruments through various dimensions such as relevant Conceptual Model domains, place of initial instrument use, language, psychometric properties, and more.

- Guide to Using the Resources

  Provides significant contributions to the community engagement field to ensure that all efforts are meaningful and impactful.

SAG
07/24/2023

Aguilar-Gaxiola S, Ahmed SM, Anise A, et al. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health: Organizing Committee for Assessing Meaningful Community Engagement in Health &Health Care Programs & Policies. *NAM Perspect. 2022*;2022doi:10.31478/202202c

COMMENTARY

Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health

Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies

February 14, 2022

"Knowing is not enough; we must apply. Willing is not enough; we must do."—Goethe

Introduction

People and the communities they are a part of—defined as "groups of people affiliated by geographic proximity . . . or similar situations to address issues affecting the well-being of those people"—are deeply impacted by the systems that drive and influence their health; however, they are often not included in the process to create or restructure programs and policies designed to benefit them (CDC, 2011). When health and health care policies and programs designed to improve outcomes are not driven by community interests, concerns, assets, and needs, these efforts remain disconnected from the people they intend to serve. This disconnect ultimately limits the influence and effectiveness of interventions, policies, and programs.

Over the last several years, health and health care entities, including advocacy organizations, philanthropic and funding agencies, care systems and hospitals, and academic and research organizations, among others, are recognizing the need to engage the communities they serve. Yet, many entities only conduct superficial engagement— the community is denied access to the decision-making process, and interactions tend toward tokenism and marginalization, or the community is simply informed of plans or consulted to provide limited perspectives on select activities (Carman and Workman, 2017; Facilitating Power, 2020). True, **meaningful community engagement** requires working collaboratively with and through those who share similar situations, concerns, or challenges. Their engagement serves as "a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. [It] often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (CDC, 2011). Shifting toward meaningful community engagement often requires decision makers to defer to communities and move to power sharing and equitable transformation—necessary elements to ensure sustainable change that improves health and well-being (Facilitating Power, 2020). It is important to note that meaningful community engagement requires working closely with communities to understand their preferences on how, when, and to what level and degree they want to be engaged in efforts. Some communities may prefer to only provide input or be consulted at certain times, while others may prefer shared power and decision-making authority.

Tools and resources are available to provide practical guidance on and support for community engagement (CDC, 2011). Yet, the intention to engage does not always translate to or ensure effective engagement (Carman and Workman, 2017; Facilitating Power, 2020). In other words, the fundamental question is not whether entities think they are engaging communities but whether communities feel engaged. Bridging this gap requires the ability to define meaningful community engagement and assess its impact—especially related to specific health and health care programs, policies, and outcomes.

With these realities in mind, the National Academy of Medicine's Leadership Consortium: Collaboration for a Value & Science-Driven Health System, with funding from the Robert Wood Johnson Foundation and guidance from an Organizing Committee, is advancing a project to identify concepts and metrics that can best assess the extent, process, and impact of community engagement. The Organizing Committee comprises experts in community engagement—community lead-

ers, researchers, and policy advisors—who are diverse in many ways, including geographic location, race and ethnicity, nationality, disability, sexual orientation, and gender identity (see *Box 1*). This effort aims to provide community-engaged, effective, and evidence-based tools to those who want to measure engagement to ensure that it is meaningful and impactful, emphasizing equity as a critical input and outcome. As work began on the project, the Organizing Committee realized the need for a conceptual model illustrating the dynamic relationship between community engagement and improved health and health care outcomes. This commentary will describe how the Organizing Committee arrived at the conceptual model, the critical content that the model contains and expresses, and how the model can be used to assess meaningful community engagement.

Background on the Development of the Conceptual Model

The Organizing Committee identified the need for a new conceptual model that could be used by a range of stakeholders, including federal, state, and local agencies; tribal communities; advocacy and community-based groups; funders, philanthropists and financiers; academic institutions; care systems, health centers, and hospitals; and payers, plans, and industry. The Organizing Committee additionally highlighted important considerations for the conceptual model design and development process.

The Need for a New Conceptual Model

An analysis of the peer-reviewed literature and organizational websites for frameworks and conceptual models of engagement identified over 20 examples. Several models explicitly focused on partnership processes and levels of engagement. Other models connected engagement to factors influencing health, interventions, policy making, community-based participatory research (CBPR), and patient-centered comparative effectiveness research. Only a few models associated engagement to outcomes, indicators, or metrics. One model, drawing from CBPR evaluation, connected partnership characteristics, partnership function, partnership synergy, community/policy-level outcomes, and personal-level outcomes (Khodyakov et al., 2011). However, this model did not identify the role of diversity, inclusion, and health equity as core components of partnership characteristics and functioning, did not include health equity as a key outcome or goal of partnerships, and was developed to support research partnerships.

Another model, grounded in academic and community partnerships and CBPR, framed the interplay between contexts, partnership processes, intervention research, and intermediate (e.g., policy environment, sustained partnership, shared power relations in research) and long-term (e.g., community transformation, social justice, health/health equity) outcomes (Wallerstein et al., 2020). While this model includes health equity as an outcome, the inputs and some outcomes are focused on academic-community research partnerships. None of the identified models examined opportunities to assess community engagement and the influence and impact it could have in health and health care policies and programs broadly, incorporating diversity, inclusion, and health equity into the framework. The Organizing Committee felt strongly that an additional model was needed to reinforce existing conceptual models—one that provides a paradigm for the factors needed to assess the quality and impact of meaningful community engagement across various sectors and partnerships and one that simultaneously emphasizes health equity and health system transformation.

The Process and Methodology for Designing the Conceptual Model

To guide the design and refinement of the new conceptual model for assessing meaningful community engagement, the Organizing Committee focused on eight foundational standards. An effective conceptual model will:

- **Define what should be measured in meaningful community engagement, not what is currently measured.** On the premise that society "measures what matters most," and "what is measured gets done," the Organizing Committee wanted the conceptual model to focus on the outcomes needed to guide the measures and metrics of meaningful community engagement, not being limited by what already exists in the literature. The development of the conceptual model and areas for assessing meaningful community engagement leveraged the wealth of knowledge, expertise, and experience of the Organizing Committee and were not constrained by whether the metrics were available. This conceptual model represents the Organizing Committee's aspirational ideal of what matters, what should be measured, and what should be done to support meaningful community engagement.

BOX 1 | Organizing Committee for Meaningful Community Engagement

- **Sergio Aguilar-Gaxiola,** University of California, Davis (co-chair)
- **Syed M. Ahmed,** Medical College of Wisconsin
- **Ayodola Anise,** National Academy of Medicine
- **Atum Azzahir,** Cultural Wellness Center*
- **Kellan E. Baker,** Whitman-Walker Institute
- **Anna Cupito,** National Academy of Medicine (until July 2021)
- **Milton Eder,** University of Minnesota
- **Tekisha Dwan Everette,** Health Equity Solutions
- **Kim Erwin,** IIT Institute of Design
- **Maret Felzien,** Northeastern Junior College*
- **Elmer Freeman,** Center for Community Health Education Research and Service
- **David Gibbs,** Community Initiatives
- **Ella Greene-Moton,** University of Michigan School of Public Health
- **Sinsi Hernández-Cancio,** National Partnership for Women & Families (co-chair)
- **Ann Hwang,** Harvard Medical School (co-chair)
- **Felica Jones,** Healthy African American Families II*
- **Grant Jones,** Center for African American Health*
- **Marita Jones,** Healthy Native Communities Partnership*
- **Dmitry Khodyakov,** RAND Corporation and Pardee RAND Graduate School
- **J. Lloyd Michener,** Duke School of Medicine
- **Bobby Milstein,** ReThink Health
- **Debra S. Oto-Kent,** Health Education Council*
- **Michael Orban,** Orban Foundation for Veterans*
- **Burt Pusch,** Commonwealth Care Alliance*
- **Mona Shah,** Robert Wood Johnson Foundation
- **Monique Shaw,** Robert Wood Johnson Foundation
- **Julie Tarrant,** National Academy of Medicine
- **Nina Wallerstein,** University of New Mexico
- **John M. Westfall,** American Academy of Family Physicians
- **Asia Williams,** National Academy of Medicine
- **Richard Zaldivar,** The Wall Las Memorias Project

*Provided perspectives on the conceptual model through in-depth interviews

- **Be sufficiently flexible to measure engagement in any community.** Community goes beyond geography and represents a group of individuals who share common and unifying traits or interests. Community "can refer to a group that self-identifies by age, ethnicity, gender, sexual orientation . . . faith, life experience, disability, illness, or health condition; it can refer to a common interest or cause, a sense of identification or shared emotional connection, shared values or norms, mutual influence, common interest, or commitment to meeting a shared need" (WHO, n.d.). The Organizing Committee recognizes the importance of considering intersectionality in defining community, as individuals often belong to multiple and intersecting identities. As such, examples of community could include faith-based organizational networks partnering to improve health across a state, neighbors in a local area seeking environmental changes to improve health and well-being, or a multi-stakeholder network with community-based organizations, primary care providers, and hospitals addressing opioid addiction. The conceptual model should be flexible for use in assessing the impact and influence of engagement in any community.
- **Define health holistically.** The conceptual model should focus on physical and mental

health and well-being (Roy, 2018). Often, references to health are only aligned with physical health. The conceptual model should consider that health is not just about being free of disease or infirmity, but that individuals and communities have the right to thrive—to reach "the enjoyment of the highest attainable standard of health" (WHO, n.d.).

- **Allow the community to see itself in or identify with the language, definitions, and context.** The conceptual model should make sense to the community, be usable by the community, and be written in language familiar to the community. The model and the language used in it should allow communities to see themselves in it and emphasize the positive aspects of the community. At the same time, the Organizing Committee recognized that all communities are not monoliths. The conceptual model should be adaptable to the needs of the communities using it—each community and its partners should be able to review the terms and measurement areas presented in the model and collaboratively decide on how to define, apply, modify, or implement them to support their needs.
- **Embed equity throughout the model.** Equity must be the central focus for every decision related to conducting meaningful community engagement and thinking about person-centered health and health care (Simon et al., 2020). Equitable and continued engagement with those traditionally left out of conversations and decision making about the health and health care systems, programs, interventions, and policies that affect them opens a pathway to true health system-wide transformation. The conceptual model should reflect that transformation is not possible without systematically embedding equity into its core components, not just its outcomes.
- **Emphasize outcomes of meaningful community engagement.** The Organizing Committee underscored the importance of the processes, strategies, and approaches used in engagement. Each community is different and wants to be engaged in various and multiple ways. The Organizing Committee recognized that there are myriad toolkits, reports, articles, and examples on how to engage communities. Certainly, more work is needed to understand the influence of and measure these processes to achieve desired outcomes. However, the conceptual model is being developed to support outcome-based accountability. If stakeholders cannot achieve meaningful community engagement based on the selected agreed-upon outcomes, modifying or changing their engagement process should be considered. The main purpose of this conceptual model is to reflect the dynamic relationship between engagement and outcomes, not present or address processes for engagement.
- **Present a range of outcome options for various stakeholders.** As many are committed to assessing the impact of community engagement on health and health care policies and programs, the conceptual model should be relevant to and usable by the range of aforementioned stakeholders. This conceptual model should explain the connection between community engagement and outcomes, and the Committee insisted that a range of options be provided for assessing community engagement to reflect local priorities and interests rather than assume that all communities want or need the same outcomes. In other words, different communities will want to focus on different outcomes. Additionally, the model should support various stakeholders (e.g., federal, state, and local agencies; tribal communities; advocacy and community-based groups; funders, philanthropy, and financiers; academic researchers and institutions; and payers, plans, and industry) looking to evaluate the impact and influence of engagement with the community in health and health care policies and programs.
- **Communicate the dynamic and transformative nature of engagement.** The Organizing Committee believed that the conceptual model should place community and community engagement at the center and that all impact and influence should accelerate toward meaningful outcomes that ultimately ensure health equity through transformed systems for health. The image and shape used to depict the relationship between community engagement and outcomes should be dynamic, reflecting the movement toward equity and system transformation when communities are actively and meaningfully engaged.

A three-stage methodological process that leverages these foundational and guiding standards was used to design the conceptual model. In stage one, a subset of 14 Organizing Committee members, including community leaders, researchers, and policy advisors, identified the key overarching components and outcomes to include in the model over the course of several discussions. In stage two, extensive in-depth interviews were conducted with a select group of Organizing Committee members, representing 11 community leaders not involved in stage one, which generated a dozen iterations of the model. The community leaders detailed specific terms, phrases, language, and additional components needed to ensure that the conceptual model was authentic to community perspectives, easy to understand, aligned with other efforts on community engagement, complementary to existing models, and recognizable by those who would benefit the most by using the model. The community leaders also discussed and modified the relationships between the key components and appropriate alignment among outcomes. During this stage, community leaders reviewed outcomes identified in a preliminary literature search to see if elements were missing from the model. Only one additional outcome was added at this time. In stage three, the entire Organizing Committee was re-engaged to review, refine, and agree on the resulting conceptual model presented in this commentary.

Review of the Conceptual Model

The conceptual model titled *Achieving Health Equity and Systems Transformation through Meaningful Community Engagement,* and also known as the Assessing Community Engagement (ACE) Conceptual Model, centers community engagement and core engagement principles (see *Figure 1*). Four "petals" or "propellers" emanate from the center and radiate from left to right, reflecting major meaningful domains and indicators of impact that are possible with community engagement. Impact in these domains leads to the fundamental goal of health equity and systems transformation and is contextualized by the drivers of health; drivers of change; and social, political, racial, economic, historical, and environmental context. While the ACE Conceptual Model can be viewed as linear and sequential, end users also have the flexibility to focus on specific indicators depending on needs and interests. Below is a description of the details and definitions of all the key components of the conceptual model.

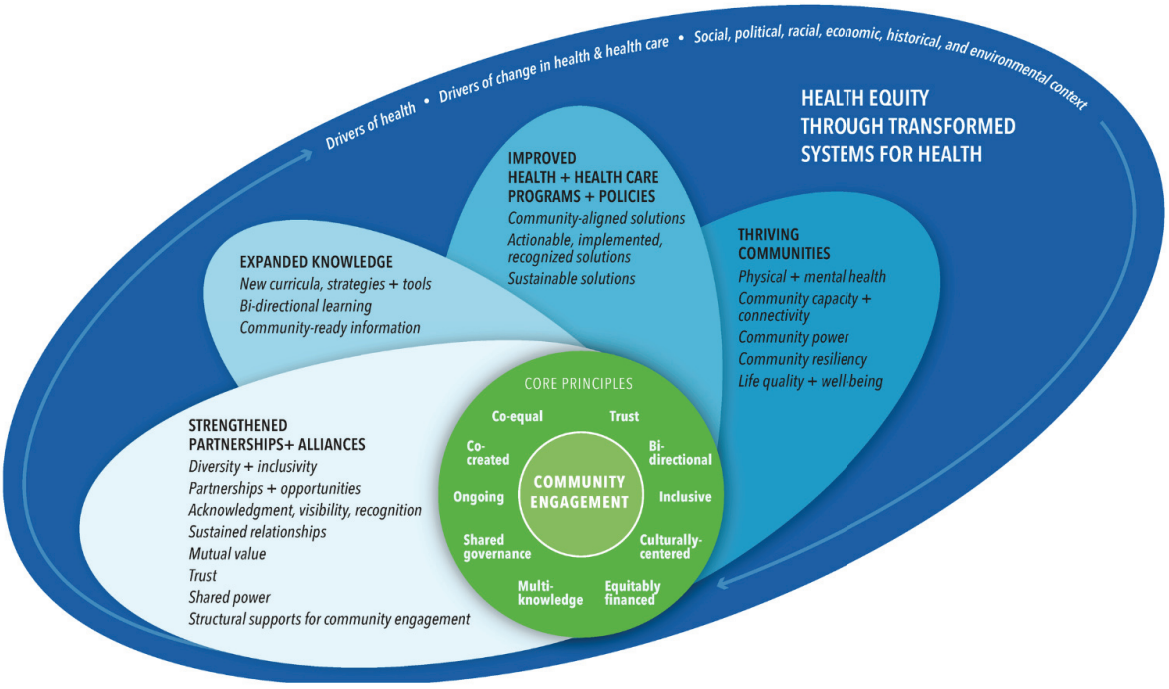


FIGURE 1 | A Dynamic Relationship: Achieving Health Equity and Systems Transformation through Meaningful Community Engagement

Community Engagement

Community engagement is the linchpin or central focus of the conceptual model. Engagement of the community, as defined above, represents both the start and the hub of movement toward outcomes. It is only with community engagement that it is possible to achieve and accelerate progress toward the goal of health equity through transformed systems for health.

Core Principles

The core principles identify attributes that should be present in the process of community engagement. Those involved must ensure that community engagement is grounded in trust, designed for bidirectional influence and information flow between the community and partners, inclusive, and premised on culturally centered approaches. The core principles also include equitable financing, multi-knowledge, shared governance, and ongoing relationships that continue beyond the project time frame and are authentic and enduring. Engagement should be co-created, and participants should be considered coequal. Principle-informed community engagement creates a readiness that can propel teams into productive motion and accelerate engagement outcomes and the ultimate goal of health equity and systems transformation.

Domains and Indicators of Meaningful Engagement

With community engagement and the core principles, it is possible to understand if meaningful engagement is taking place by assessing some or all of the outcomes based on the needs and interests of the community. Therefore, the Organizing Committee developed a taxonomy to classify, describe, and standardize outcomes to assess community engagement (Aguilar-Gaxiola, 2014). The taxonomy used in the ACE Conceptual Model considers domains, indicators, and metrics.

The conceptual model posits four broad categories or domains of measurable outcomes:

- Strengthened partnerships and alliances
- Expanded knowledge
- Improved health and health care programs and policies
- Thriving communities

Under each domain are potential and relevant indicators. The conceptual model presents 19 mutually exclusive indicators divided across the four domains. As indicators are not yet quantifiable, each indicator is, in turn, associated with specific metrics. These metrics are the questions that are both supported by results and that can be used to assess if the engagement taking place is meaningful. The Organizing Committee identified metrics associated with meaningful community engagement through a literature review and aligned them with the indicators presented on the conceptual model. Given the space limitations in the conceptual model, only domains and indicators are listed; the metrics identified in the literature and associated with the indicators will be made available later.

Ultimately, with community engagement and its core principles embedded into all collaborations and partnerships, movement and progress should occur in multiple domains and indicators present in the model. Below are explanations on how the Organizing Committee characterized the domains and indicators in the conceptual model.

Strengthened Partnerships and Alliances

The first assessment domain identified by the Organizing Committee relates to strengthened partnerships and alliances, which the Committee defines as how participants emerge from engagement with new or improved relational benefits that are carried forward. This domain also reflects the qualities of leadership that allow alliances and partnerships to be strengthened, and it has the following eight indicators:

- Diversity and inclusivity
- Partnerships and opportunities
- Acknowledgment, visibility, and recognition
- Sustained relationships
- Mutual value
- Trust
- Shared power
- Structural supports for community engagement

Diversity and inclusivity ask for constant consideration of the representation, inclusion, and lived experiences of those engaged in the efforts. Representation should be intentionally diverse, comprising multicultural, multiethnic, and multigenerational perspectives, particularly those not traditionally invited or involved in improving health and health care policies and programs. Perspectives should reflect the composition of the community, be based on the culture of the community, and reflect multidisciplinary expertise from the community. Diversity and inclusivity should also be reflected in the intentional integration of the interests and, importantly, in knowledge, resources, and other valuable entities from all community members during conversations and deliberations.

Partnerships and opportunities ensure that those engaged are fully benefiting from participation through deepened and mutually supported relationships. This indicator assesses whether participants have benefited from bidirectional mentorship or other forms of professional investment; gained access to new financial or nonfinancial opportunities; received certificates, earned degrees, or otherwise benefited from skills development; or shared and connected to an expanded network of partners, influencers, and leaders.

Acknowledgment, visibility, and recognition reflect how community participants are seen and recognized as contributors, experts, and leaders and can benefit from their participation. This indicator encompasses public acknowledgment of participant contributions and recognizes the legitimacy of the partnership.

Sustained relationships require that the community, institutions, and relevant disciplines maintain continuous and ongoing conversations that are not time-limited or transactional. The community should be engaged at the beginning of an effort and normalized as an essential stakeholder. Involvement and engagement of the community should have depth and longevity.

Mutual value ensures that communities engaged are equitably benefiting from the partnership. This indicator requires balanced engagement between the community and others involved in the partnership, as marked by reciprocity that considers how the community will benefit from, not just contribute to, the effort. The value exchange can be financial or nonfinancial but must be defined by, not prescribed for, the community. Mutual value is grounded in the need for understanding and respect for the community and all partners. It requires valuing the knowledge and expertise of all individuals, agreeing to a shared set of definitions and language, and committing to bidirectional learning.

Trust is a core component of engagement. It requires showing up authentically, being honest, following through on commitments, and committing to transparency in order to build a long-lasting and robust relationship. Genuine partnerships grounded in trust require change on the part of all partners. Trust also requires that entities engaging communities commit themselves to being *trustworthy*. Mistrust among communities of representatives of health care and other systems is often an adaptive response to historical and contemporary injustice perpetrated by these systems. A foundational component of building trust with communities is demonstrating that community trust is warranted and will not be abused or exploited.

Shared power is fundamental to strong and resilient partnerships with the community. Shared power reflects that community participants are involved in leadership activities such as codesigning and developing the partnership's shared vision, goals, and responsibilities. It emphasizes that community members have influence and can see themselves and their ideas reflected in the work. Shared power includes true equitable partnership and governance structures that ensure community partners occupy leadership positions and wield demonstrable power equivalent to other partners. Shared power relies on collaborative and shared problem solving and decision making, joint facilitation of activities, and shared access to resources, such as information and stakeholders.

Structural supports for community engagement provide the infrastructure needed to facilitate continuous community engagement. This indicator asks about operational elements for engagement such as established and mutually agreed-upon financial compensation for community partners, requirements for equitable governing board composition, protocols to ensure integration of community partners into grant writing and management, and equitable arrangements for data sharing and ownership agreements, among others. These structural supports ensure the longevity of community engagement and the partnership's sustainability over time.

Expanded Knowledge

The second domain, expanded knowledge, refers to the creation of new insights, stories, resources, and evidence, as well as the formalization of respect for existing legacies and culturally embedded ways of knowing that are unrecognized outside of their communities of origin. When co-created with community, expanded knowledge creates new common ground and new thinking, and can catalyze novel and more equitable approaches to the transformation of health and health care. The three indicators under expanded knowledge include new curricula, strategies, and tools; bidirectional learning; and community-ready information.

New curricula, strategies, and tools are formal products of community engagement that encapsulate new knowledge and evidence in ways that allow it to be disseminated, accessed, replicated, and scaled. This indicator looks for the development of new curricula, strategies, and tools that enable other partnerships to learn from, build on, and advance new practices in their community engagement.

Bidirectional learning is when the community and partners can collaboratively generate new knowledge, stories, and evidence that reframe how community is described and appreciated. This indicator looks for representations of community that are asset- and resiliency-based, improved cultural knowledge and practices among partners, and broader cultural proficiency and respect for community differences across the partnership. Bidirectional learning equally values all forms of knowledge and wisdom, including stories and lived experience.

Community-ready information is an indicator referring to the creation of actionable findings and recommendations that are returned to the community in ways they understand, value, and can use.

Improved Health and Health Care Programs and Policies

The third domain of the conceptual model is improved health and health care programs and policies. This is the stated goal of many partnerships; however, creating programs and policies that communities want and will use—a prerequisite to effectiveness in real-world settings—requires alignment between those who design programs, services, and policies and those who are expected to use them. Community engagement is essential to creating a productive context for developing solutions that are "fit to purpose," as well as embraced and championed by those they are designed to serve. The three indicators within this category include community-aligned solutions; actionable, implemented, recognized solutions; and sustainable solutions.

Community-aligned solutions come from and speak to the priorities of the community. This indicator looks for community-defined problems, shared decision making, and cooperatively defined metrics. It also ensures that care models, communication, and solutions are tailored to the community setting and needs.

Actionable, implemented, and recognized solutions are important indicators of success. Results should be visible within and across communities. This indicator looks for solutions that are recognized and endorsed by community members and leverage the assets in the community and the partnerships that produced them; are referenced publicly or within academic literature; and show measurable adoption, growth, and reach.

Sustainable solutions reference new interventions, programs, and policies that can extend past their initial period of support. This indicator looks for residual infrastructure and other resources that remain in the community to support sustainability and further adjust or refine solutions in the future, if needed.

Thriving Communities

As motion accelerates through strengthened partnerships and alliances, expanded knowledge, and improved health and health care policies and programs, assessing the impact of community engagement moves to the fourth domain: thriving communities. The Organizing Committee identified five indicators that suggest engagement has led to thriving communities:

- Physical and mental health
- Community capacity and connectivity
- Community power
- Community resiliency
- Life quality and well-being

Physical and mental health refer to a "whole-person" definition of health reflected in a community's physical and mental health status. Physical and mental health include a shared awareness and view of health and health-related activities, self-efficacy in managing health and chronic conditions, shared decision making in health care treatments and priorities, increased confidence and capacity to make decisions that improve an individual's own health, and increased resiliency.

Community capacity and connectivity speak to growth in skills and capacity of the community, both as individual members and as a whole, to act on its own behalf. This indicator highlights the connectivity between community members and available resources, how engaged and activated community members are, and the investments available to develop new community leaders (e.g., financial, educational, career).

Community power manifests in a sustained paradigm shift that ensures processes and procedures are favored, initiated, and guided by the community. Community power arises with an increased rate of new efforts in the community and new efforts that are defined, initiated, and owned by the community. Community power is also indicated by cultural change—including changes in community dynamics, such as expectations that they will be meaningfully invited to and want to participate in problem solving and priority setting and will experience true equity (e.g., social equity, racial equity, health equity, equity across the drivers of health).

Community resiliency refers to the overall strength of a community and its internal capacity to self-manage. This indicator reflects the ability of the community to recognize and mount a locally relevant response to new adversities and to engage and advance culturally effective strategies to strengthen the community over time. The inherent culture and strengths of the com-

munity should be both visible and valued. Importantly, resiliency must not be invoked as a backstop for initiatives that perpetuate trends of a lack of external investments, protections, and support for the community. In other words, resilience is valuable for the internal benefits and strengths that it generates among community members; it is not, however, a replacement for adequate and tangible external investments in the resources that communities need to thrive.

Life quality and well-being refer to improvements in the drivers of health (e.g., education, economic and racial justice, built environment). Life quality and well-being highlight the ability to heal, hold hope for the future, and experience greater joy, harmony, and social equity.

Health Equity through Transformed Systems for Health

When community engagement takes place with core principles guiding its processes and activities, it propels strengthened partnerships and alliances, expanded knowledge, improved health and health care programs and policies, and healthier communities. Improvements in these domains and their associated indicators create motion and catalytic action that moves us toward health equity and well-being through transformed systems.

Drivers of Health; Drivers of Change; and Social, Political, Racial, Economic, Historical, and Environmental Context

The domains and indicators that align with meaningful community engagement and lead to health equity through transformed systems for health are influenced by several contextual factors. *Drivers of health,* many of which align with the social determinants of health, expand far beyond "traditional" factors like health status and health care into food, transportation, housing, community attributes, affordable child care, and economic and racial justice, among many others. *Drivers of health* extend to the factors that ultimately influence and impact well-being (Lumpkin et al., 2021; NASEM, 2017; NCIOM, 2020). *Drivers of change* are the key levers that influence stakeholder action, including data-driven, evidence-based practice and policy solutions; grassroots organizing; regulations; and financial incentives, to name a few. The relevant *social, political, racial, economic, historical, and environmental context* also underpins all community engagement efforts. It is critical to understand that the dynamic relationship between meaningful community engagement and health and health care policies and programs exists within these structural systems. The Organizing Committee believes that with meaningful community engagement, it is possible to motivate health equity through transformed systems for health and significantly transform and positively alter these contextual factors. A feedback loop is created and reflected through the arrows that move from community engagement, the core principles, and the domains of meaningful engagement through to these contextual factors.

Conclusion

The United States health and health care system reflects origins and a history that did not center communities as true partners in designing, implementing, evaluating, and redesigning the system. The Organizing Committee believes that community engagement is not a supplement to enacting better health and health care policies but rather its foundation. The increased focus on community engagement in the health and health care system over the years represents an opportunity for change to ensure meaningful and sustainable impact. The Organizing Committee believes now is the time to catalyze and accelerate the paradigm shift toward engagement to ensure system transformation and equity. Sustained and widespread changes toward improved health and well-being cannot occur until systems change, and that cannot happen without the engagement of those closest to the challenges and the solutions. The processes to engage the community are essential, and assessing and evaluating the engagement is just as essential to understanding whether and how true impact occurs. Without this critical step, it is impossible to truly understand where to focus efforts to transform the health system. Health and health care stakeholders must measure what matters—community engagement—and ensure that it is meaningful.

The ACE Conceptual Model is only one major element of the work needed to ensure that stakeholders can assess the engagement with community. As part of this effort, the Organizing Committee will also be:

- **Developing impact stories** told through videos and other creative modes to demonstrate how different partnerships have assessed their engagement, the influence that engagement has had on their communities, and the alignment of their outcomes with the domains and indicators in the conceptual model. These impact stories will highlight what is possible and how transformation can take place at a community, hospital, health system, and state level.

- **Conducting a literature review search** using PubMed and other databases, as well as inclusion and exclusion criteria, to identify specific metrics or individual survey questions, tools, or questionnaires (referred to as instruments) that were developed, implemented, or evaluated with community engagement.
- **Synthesizing assessment instrument summaries** that identify instruments that align with the domains and indicators in the conceptual model. These summaries, based on findings from a literature review, will include information on how engagement was used to develop or implement the instrument, populations, and communities involved in using the instrument, psychometric properties (i.e., validity, reliability, and feasibility), the instrument's questions, and alignment with the domains and indicators in the conceptual model.
- **Developing a framework to support end users** who want to measure community engagement using the conceptual model and instruments identified.

The ACE Conceptual Model presented in this commentary is drawn from the active engagement and embedding of perspectives from community leaders, academics, researchers, and policy makers. While testing the conceptual model is needed to understand the most effective context and circumstances for its use, this model presents an additional resource for end users to support the assessment of meaningful community engagement. Further, the model reflects what the Organizing Committee believes are necessary elements of meaningful engagement that should be measured and evaluated early and often. This model is evolving and not stagnant, much like the movement depicted in the shape of the model. It represents a guiding framework to catalyze meaningful community engagement and radically propel the U.S. toward health equity through systems transformation.

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Disclaimer

The views expressed in this paper are those of the authors and not necessarily of the authors' organizations, the National Academy of Medicine (NAM), or the National Academies of Sciences, Engineering, and Medicine (the National Academies). The paper is intended to help inform and stimulate discussion. It is not a report of the NAM or the National Academies.

SOLANO COUNTY INTERDISCIPLINARY COLLABORATION AND CULTURAL TRANSFORMATION MODEL (ICCTM) INNOVATION PROJECT: FINAL EVALUATION REPORT

JUNE 2021

ACKNOWLEDGEMENTS

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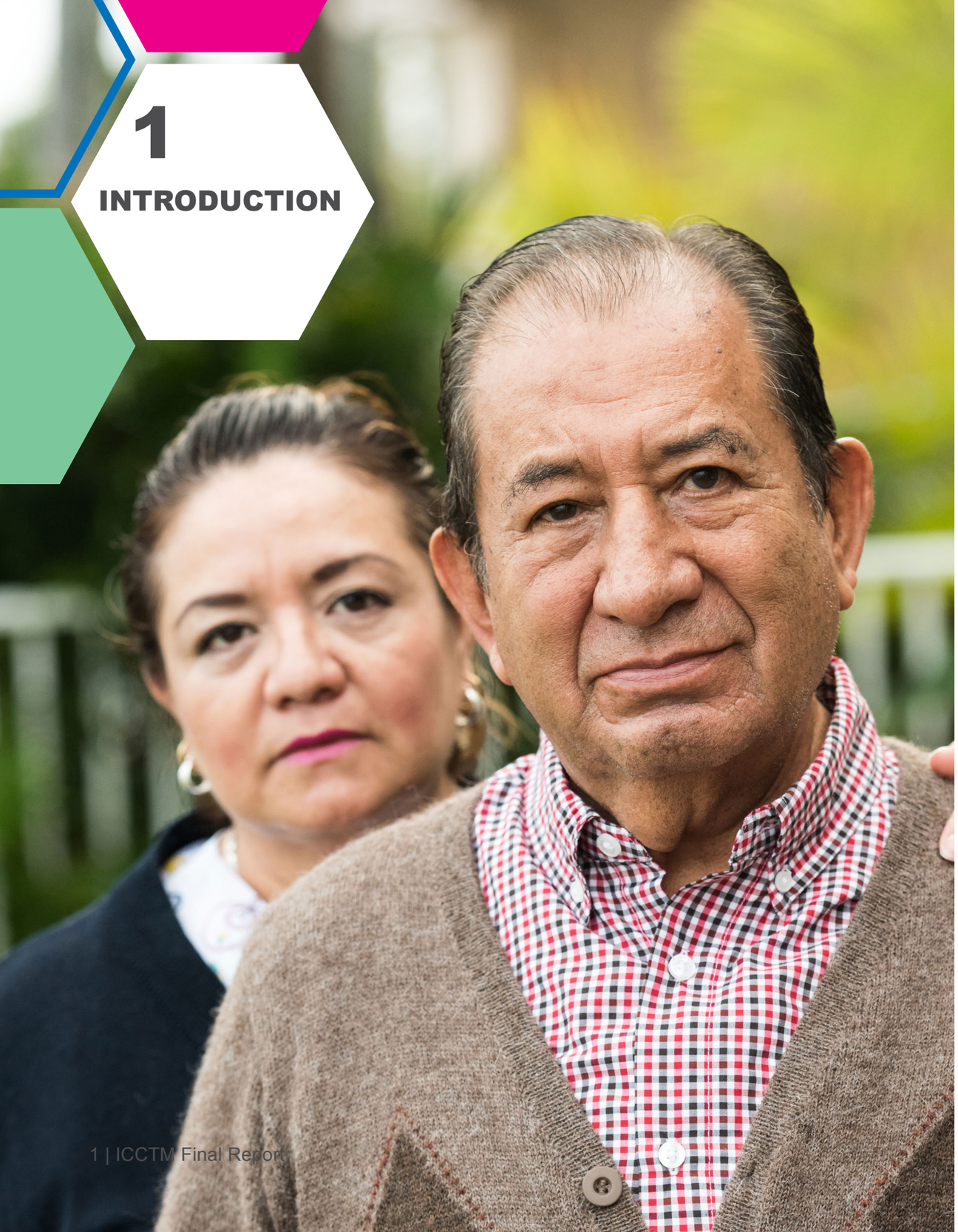


1

INTRODUCTION

EXECUTIVE SUMMARY

In 2016 Solano County Behavioral Health (SCBH), partnered with UC Davis Center for Reducing Health Disparities (CRHD), to launch a multi-phase, five-year community-initiated Mental Health Services Act (MHSA) Innovation project known as the Solano County Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM).

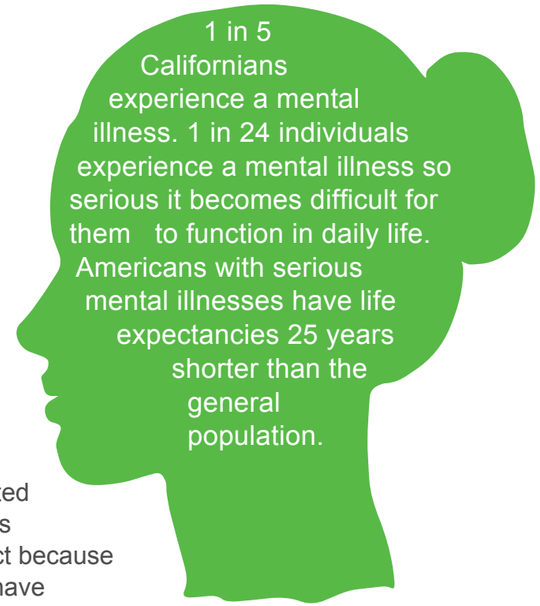
There are three core components of the ICCTM model:

1. Community-Engaged Research
2. Culturally and Linguistically Appropriate Services (CLAS) Standards
3. Quality Improvement Action Plans and Sustainability

BACKGROUND AND OVERVIEW

ICCTM focuses on key cultural and linguistic competencies required to successfully highlight the experiences and mental health needs of Filipino American, Latino, and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning) communities of Solano County.

While significant disparities also exist for other ethnic/racial groups, these three communities of focus



were selected for this project because they have historically been identified as underserved as evidenced by low penetration rates for County mental health services compared to other populations in Solano County.

Traditional approaches used to engage and serve these three communities focused mostly on the providers' skill sets with limited community engagement efforts to improve service utilization.

This project takes a decidedly collaborative and community-engaged approach to these challenges by creating a training curriculum based on the Culturally and Linguistically Appropriate Services (CLAS) Standards and information gathered directly from the three ICCTM communities of focus.

Figure 1.1
ICCTM Solano County Communities of Focus

The National CLAS Standards are a blueprint for health care organizations to advance health equity, improve quality, and help eliminate heath care disparities.

This education, training, and problem-solving process brought together multi-sector workgroups comprised of consumers, community and organizational leaders, advocates, County and contract behavioral health staff, key community partners, and staff from the University of California, Davis to work with the three communities of focus shown in **Figure 1.1.**

The ICCTM Project is funded by the California MHSA Innovation component. That Act set a 1% tax on personal adjusted gross income above $1 million and earmarked those tax dollars to transform California's mental health system into a consumer and family driven culturally and linguistically appropriate and recovery-oriented system (Cashin, et al. 2008).

CORE COMPONENTS OF ICCTM PROJECT

Community-Engaged Research was used to increase understanding of mental health disparities associated with race, ethnicity, gender identity, sexual orientation, and socio-economic status, as well as community engagement to achieve mental health equity and increase access to care (Minkler & Wallerstein, 2008).

Culturally and Linguistically Appropriate Services (CLAS) Standards – CLAS Standards are designed to ensure that mental health consumers can access, utilize, and benefit from mental health services in the context of their language, race, ethnicity or other personal characteristics (Hollinger-Smith, 2016).

Quality Improvement Action Plans and Sustainability – A focus on systematic and continuous actions that lead to measurable improvement in mental health services and the health status of ICCTM communities of focus that sustain over time.

Project Phases

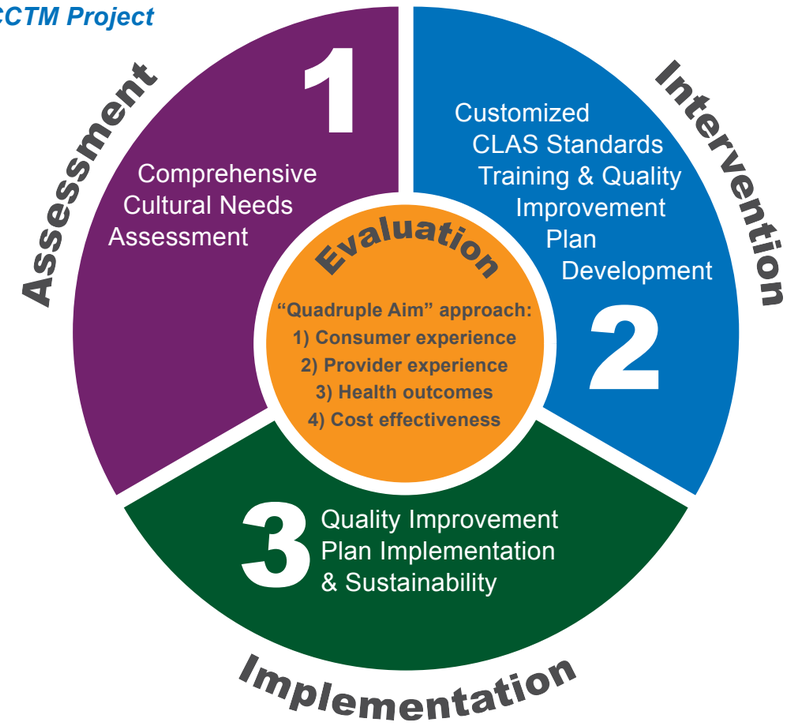
The ICCTM Project is comprised of three phases of work aligned with the core values of the MHSA.

Phase 1: Comprehensive Cultural Needs Assessment

This first phase included a comprehensive cultural needs assessment. Stakeholders, cultural brokers, and community leaders representing the three ICCTM communities of focus shared their experiences with accessing and using mental health services in Solano County through key informant interviews, focus groups, community forums and organizational surveys.

Figure 1.2
Three Components of SCBH and ICCTM Project

Figure 1.3
Three Phases of the ICCTM Project



Phase 2: Customized CLAS Standards Training and Quality Improvement Action Plan Development

The second phase involved creating a custom training (Providing Quality Care with CLAS Training) and coaching based on information collected during the first phase. Training participants were recruited from different sectors throughout Solano County, including County and contracted behavioral health staff, various county partners such as Child Welfare, Public Defenders Office, and Public Health, consumers/ family members, faith-based community, educators, community-based organizations, and law enforcement.

The program included four training sessions followed by at least five coaching sessions. In the training sessions, the participants learned about the CLAS Standards, health disparities in Solano County, and community members' ideas on how to improve access to and utilization of mental health services.

As a part of the training sessions, the participants formed small groups to develop quality improvement QI Action Plans based on the community-defined cultural and linguistic challenges and solutions.

After the training was completed, participants joined coaching sessions to strengthen their QI Action Plans. Once the QI Action Plans were developed, discussed and refined, a written document summarized the steps for SCBH to undertake the implementation of the QI Action Plans.

Phase 3: Quality Improvement Action Plan Implementation and Sustainability

This third phase focused on working with Solano County to finetune the QI Action Plans and begin implementation in a way that will help SCBH sustain efforts over time. A comprehensive evaluation of the ICCTM Project was also undertaken during Phase 3.

A strong focus on this phase is aligning all mental health efforts and working with community-based organizations to jointly partner in creating services that are culturally and linguistically appropriate.

Quadruple Aim Evaluation

This project was grounded in the Quadruple Aim framework that advocates for: improving patient experience, reducing cost, advancing population health and improving the provider experience (Berwick et al. 2008; Bodenheimer & Sinsky 2014).

A provider was defined as someone who provides direct services or treatments to mental health consumers (e.g., psychiatrists, licensed clinicians, therapists), and a non-provider as someone in support services, administration, leadership, or a volunteer role (e.g., reception/clerical, directors, supervisors, board members).

The evaluation design centered on capturing the experiences of mental health consumers and providers during their interactions, examining outcomes from these interactions within a cultural and linguistic framework, and determining the cost effectiveness of the project in sustainability and replicability.

Project Outcomes and Goals

The ICCTM Project outcomes are evaluated at three levels: individual, community, and county as shown in **Figure 1.4.** On an individual level, the CLAS training was expected to increase participant's knowledge, experience, and self-confidence in using CLAS Standards.

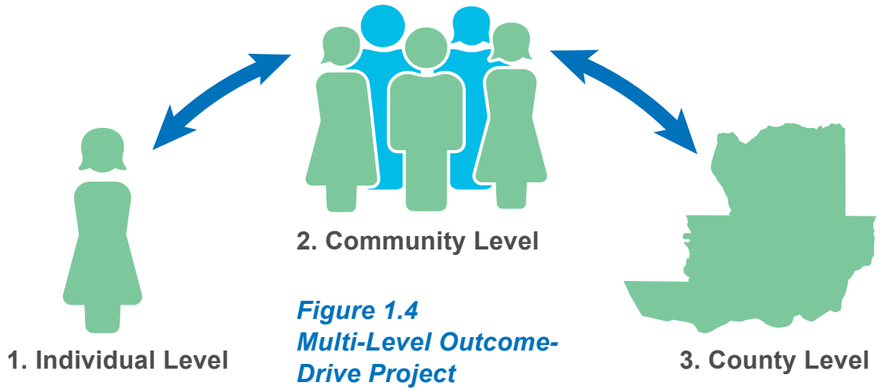


Figure 1.4
Multi-Level Outcome-Drive Project

On a community level, the expected outcomes included: (1) increasing community outreach and community engagement; (2) increasing community partnerships across the county; (3) improving awareness of mental health services; and (4) developing proven innovative strategies that decrease stigma of mental health for the three ICCTM communities of focus.

On a county (systemic) level, outcomes include: (1) improving access and utilization of mental health services for Filipino American, Latino, and LGBTQ+ communities; (2) improing consumer satisfaction and outcomes for consumers; (3) improving the provider experience; (4) increasing workforce diversity; (5) evaluating the costs vs. benefits of the project; and (6) improving organizational policies, programs and support systems to ensure and sustain cultural and linguistical competency in service delivery.

ICCTM FINAL EVALUATION REPORT

The ICCTM Project is a joint effort between SCBH and UC Davis CRHD. With coordination and evaluation provided by the University, the multi-year project has been reviewed through multiple technical studies and reports.

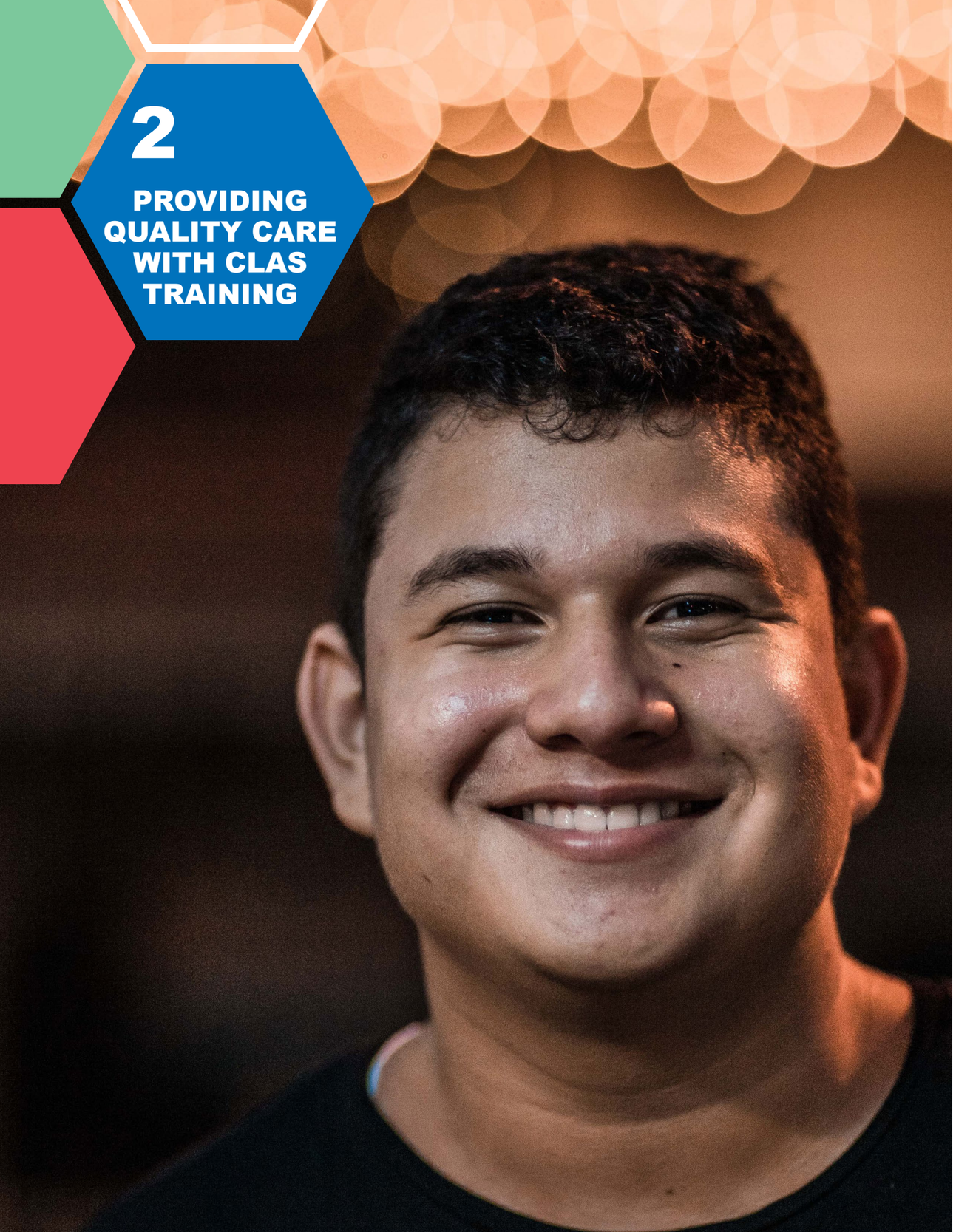
Each of the technical reports use a variety of statistical tools (eg. means, regression analysis, correlation matrix, factor analysis, etc.). This report, presents the findings of the detailed statistical analysis that can be found in the technical reports. The purpose of this community report is to present the project and its results in a manner that is more community friendly.

Note that the term LGBTQ+ is used throughout the report and includes non-cisgender consumers in all chapters except 5 and 6.

The number of non-cisgender consumers was too small to be represented separately in graphics throughout other chapters of the report. A detailed explanation of sexual orientation and gender identity is included on page 73.

Additionally, note that multiple authors contributed to the seven technical reports that were woven together into this report.

For complete technical results, references, and other information, visit the report website on the UCD CRHD website: https://health.ucdavis.edu/crhd/.



2

PROVIDING QUALITY CARE WITH CLAS TRAINING

TRAINING PROGRAM DESCRIPTION

The Providing Quality Care with CLAS (Culturally and Linguistically Appropriate Services) Training Program provided an opportunity for SCBH providers, staff, and community partners to learn how the CLAS standards could be implemented in their work.

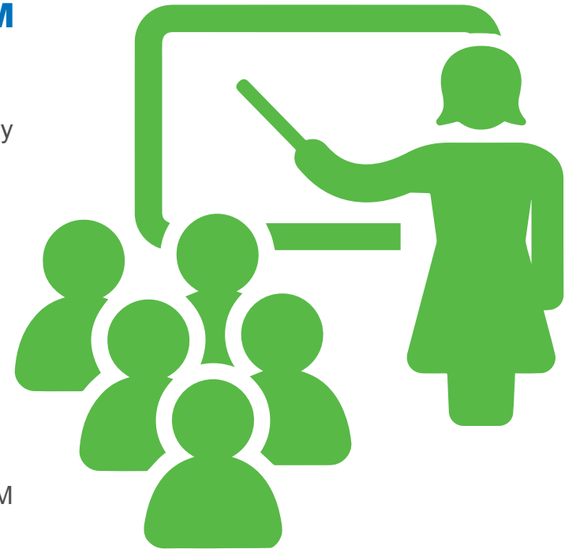
CLAS training also informed the development of Quality Improvement (QI) Action Plans to address cultural responsivity and engagement with the three ICCTM communities of focus: Filipino Americans, Latino, and LGTBQ+ persons.

Three cohorts of multi-sector partners were invited to the Providing Quality Care with CLAS Training Program held in 2018 and 2019 (**Figure 2.1, next page**).

The curriculum was developed with input from community members, SCBH and the UC Davis CRHD. It was also customized to the unique cultural and linguistic needs of the Filipino American, Latino, and LGBTQ+ communities.

Trainings were delivered by UCD Facilitators for three cohorts, over four 8-hour sessions, one of which focused specifically on the CLAS standards.

The training sessions were followed by five or more coaching sessions



varying in length over a 5-8 month period. These sessions were led by both SCBH and CRHD leaders and were designed to help small groups of trainees develop specific QI Action Plans, relevant to the three communities of focus.

Coaching sessions provided connections to critical stakeholders necessary to create and implement the QI Action Plans. They also helped each group to refine their QI Action Plan in the best way to help SCBH with the implementation.

By the Spring of 2021 QI Action Plans were in various stages of implementation within SCBH with a goal to create sustainable changes throughout Solano County.

FIGURE 2.1
CLAS TRAINING PROCESS AND CURRICULUM

1. OVERVIEW & HEALTH DISPARITIES

Overview of the CLAS training objectives highlighting health disparities and underserved populations

2. COMMUNITY NEEDS & GAPS

Community-defined challenges and needs, with solutions derived from community narratives

3. CLAS STANDARDS

Hands-on learning to help participants align their thinking and practices to the National CLAS Standards

4. QUALITY IMPROVEMENT DEVELOPMENT

Guidance for participants to develop QI Action Plans based on CLAS standards and community needs

5. COACHING

Multiple sessions for small groups of trainees to further refine specific QI Action Plans relevant to Solano County communities

PROGRAM EVALUATION

The evaluation of the training program measured two items:

1. Changes in participants' increase in knowledge of CLAS
2. Confidence incorporating a culturally responsive approach in their work

The evaluation also examined the association between participants that successfully completed the training program and their engagement behaviors for working alongside members of the Filipino American, Latino, and LGBTQ+ communities.

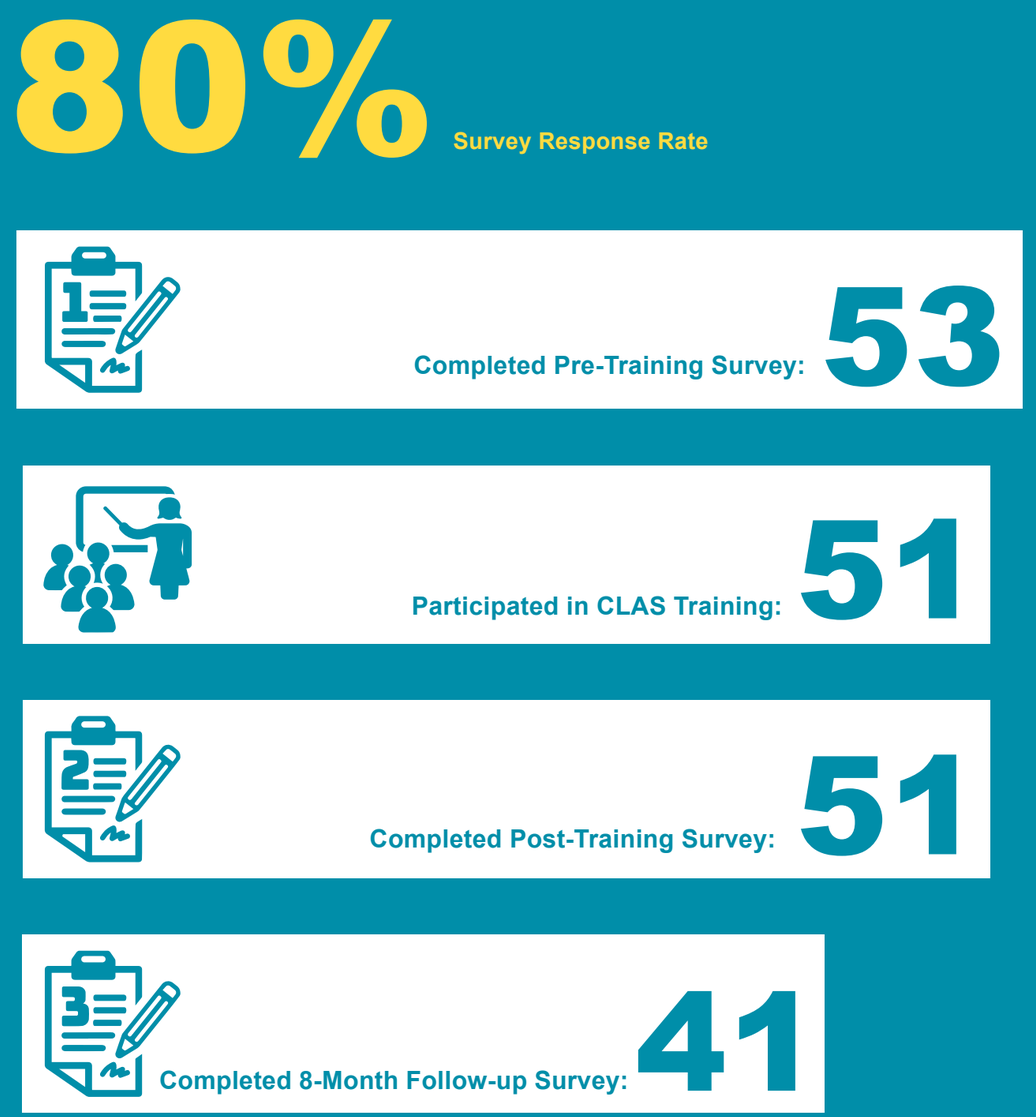
Finally, the evaluation served as an initial evidence base to assess the ICCTM Project as a model to improve the quality of mental health care delivered to communities of focus beyond the Solano County elsewhere in the state or nation.

METHODS

To assess the effectiveness of the training program, participants were surveyed at three different intervals, for an overall response rate of 80 percent as shown in **Figure 2.2**. Pre-training surveys were administered before their first day of the training and collected demographic and background information about each participant. Participants were asked to rate their knowledge, experience, and engagement with the three communities of focus.

The post-training survey was administered following the last training session and repeated the self-ratings of knowledge, experience, and engagement items. A follow-up survey was administered eight months after the completion of coaching session 4 and repeated the self-rating items to ascertain longitudinal change in knowledge, experience, and engagement. Copies of the surveys can be found on the report website.

FIGURE 2.2
TRAINING AND SURVEYS, BY THE NUMBERS



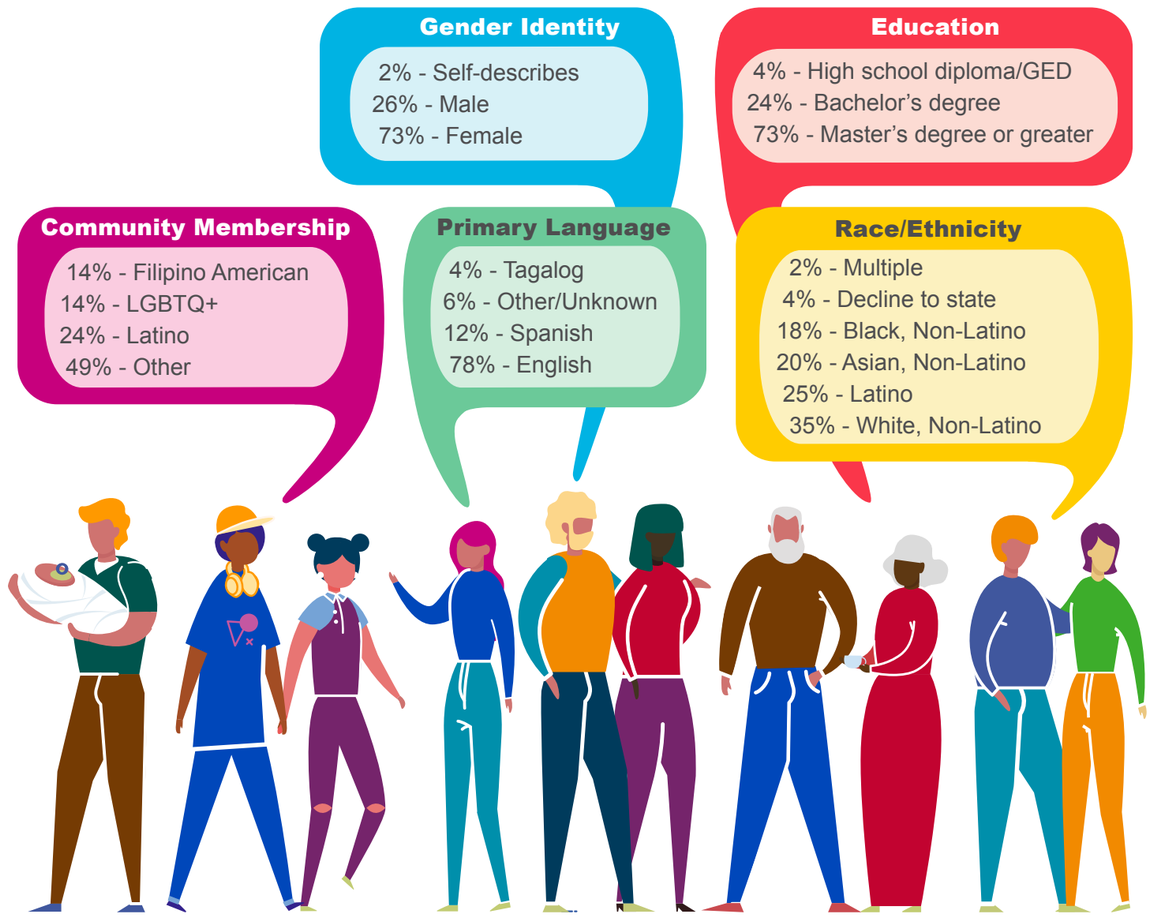
PARTICIPANT CHARACTERISTICS

Information about the training participants is listed below in **Figure 2.3** in ascending order by of the percent of each group to purposefully highlight each minority population first. Participants were employees from both within and outside SCBH and generally matched the county and partners' workforce composition in terms of gender and racial/ethnic identity.

The majority of participants (78 percent) reported English as their primary language, which highlights the value of CLAS standards and the need for language appropriateness when working with priority mono-lingual populations.

Almost two-thirds of participants resided in Solano County for at least one year which reflects the need and interest for training even among people who likely have high familiarity with the needs of the communities of focus and a potential to immerse themselves in the environments of the populations that they serve.

Participants may be particularly well suited to share their learnings as they live, work, study and worship in the Solano County and may become more aware of the importance of becoming more responsive to their cultural and linguistic needs of other people in their own community.



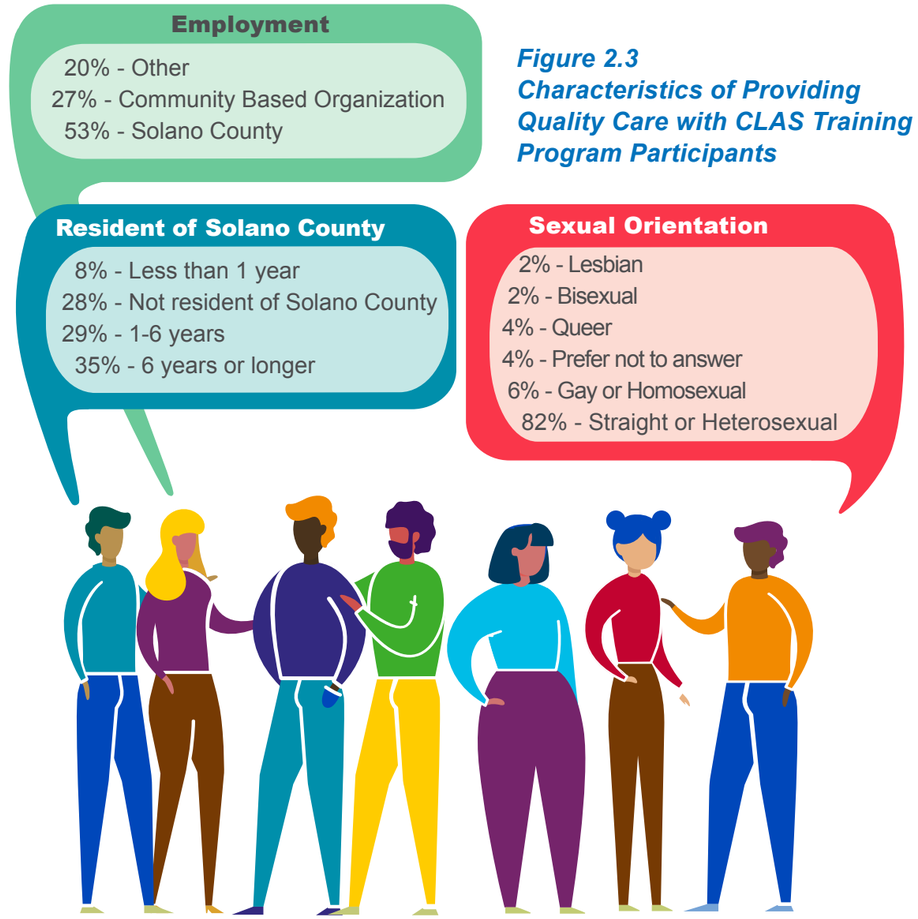


Figure 2.3
Characteristics of Providing Quality Care with CLAS Training Program Participants

MEASURES

Survey items asked respondents to rate themselves along two domains:

1. Cultural responsivity (18 items)
2. Engagement with the three communities of focus (9 items, 3 for each community).

Cultural responsivity is defined as people's ability to learn from and relate humbly to people from their own and other cultures. This measure was categorized into three sub-categories.

- Knowledge of and confidence about CLAS Standards
- Involvement with quality improvement activities
- Involvement with addressing barriers, as well as an overall composite measure

Anecdotally stakeholders from Solano County refer to community engagement as collaborative partnerships and working alongside the three communities of focus to address disparities.

Community engagement survey items measure the extent to which respondents interacted with members of the communities of focus and provided culturally appropriate services to them.

To examine the changes in the cultural responsivity measures and community engagement items comparisons were examined between the pre-training, post-training, and 8-month follow up surveys by looking at the percent of people who agreed with each question.

RESULTS

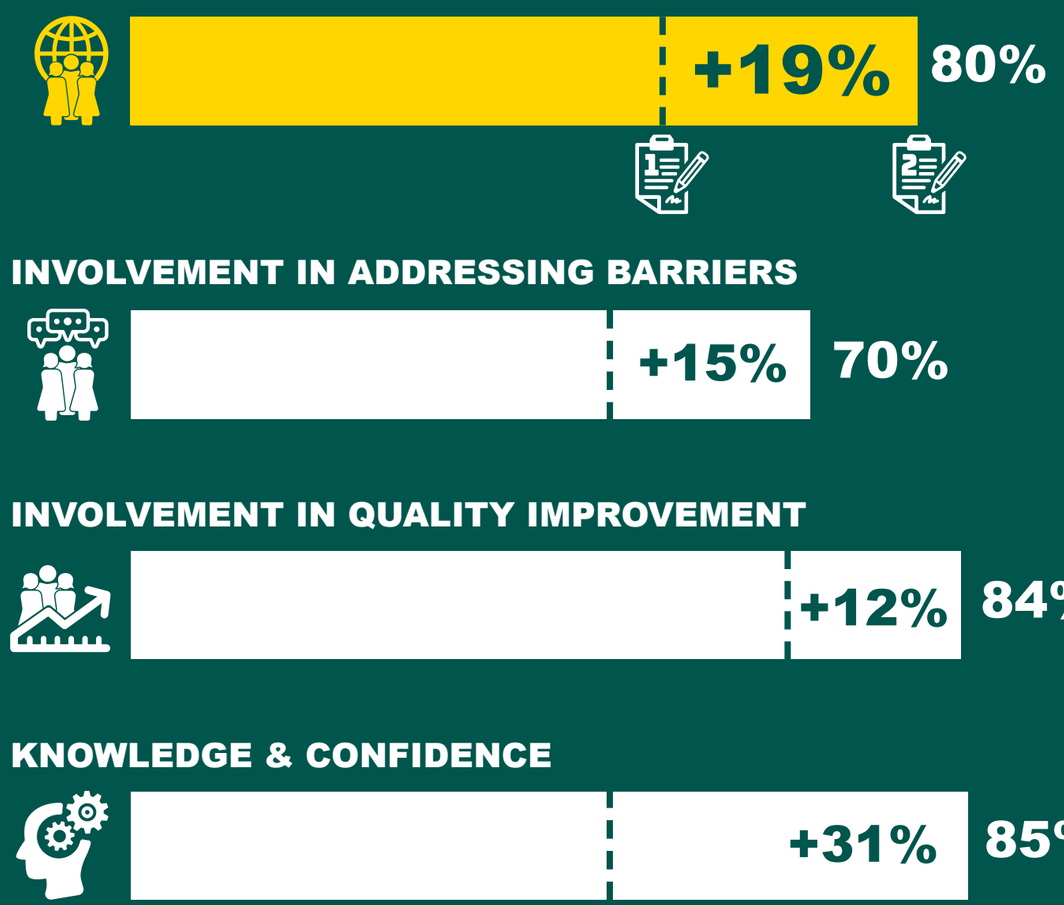
Cultural Responsivity

The change in positive responses to measures of cultural responsivity and the three subcategories in the pre-training and post-training are presented in **Figure 2.4**.

Participants reported a significant increase overall and in all three subcategories of cultural responsivity at the end of the training and at the 8-month follow-up compared to the pre-training level. As training and coaching progressed, participants maintained a steady level of cultural responsivity overall. Not surprisingly, the largest growth was in the area of knowledge and confidence in delivering CLAS, which was a primary focus of the training.

Specifically, participants on average "disagreed" with being familiar with the CLAS Standards before training, but "agreed" with being familiar with the CLAS Standards after training.

FIGURE 2.4
CHANGE IN POSITIVE RESPONSES TO MEASURES OF CULTURAL RESPONSIVITY AFTER CLAS TRAINING



Note: Dashed line represents pre-training scores for cultural responsivness, with the inset number indicating overall improvement between the pre- and post-training surveys.

Similar improvements were seen regarding their familiarity with the importance of addressing culture and language to improve mental health, awareness of efforts to address culture and language needs, and their experience with using preferred language data to better serve their clients.

Training program participants also demonstrated improvements in their working relationships with their community partners and colleagues.

Confidence about providing mental health services to individuals in each of the three communities of focus increased from before the training to the end of the training.

Of interest is the fact that confidence about providing mental health services to individuals from the Filipino American community increased the most where nearly 1 in 3 participants had an increase in comparison to only 1 in 5 people increasing their confidence about providing mental healh services to the other two communities of focus, as shown in **Figure 2.5**.

Participants also more frequently had conversations to understand the needs of the three communities of focus. The greatest increase was in having conversations to understand the needs of the Filipino American community.

Participants more frequently worked to improve services geared towards individuals in the communities of focus, again with the increased frequency for working to improve services for the Filipino American community being greatest.

Along with answering questions about change in confidence in providing services, **Figure 2.5** also details the percent of respondents who did feel confident post training.

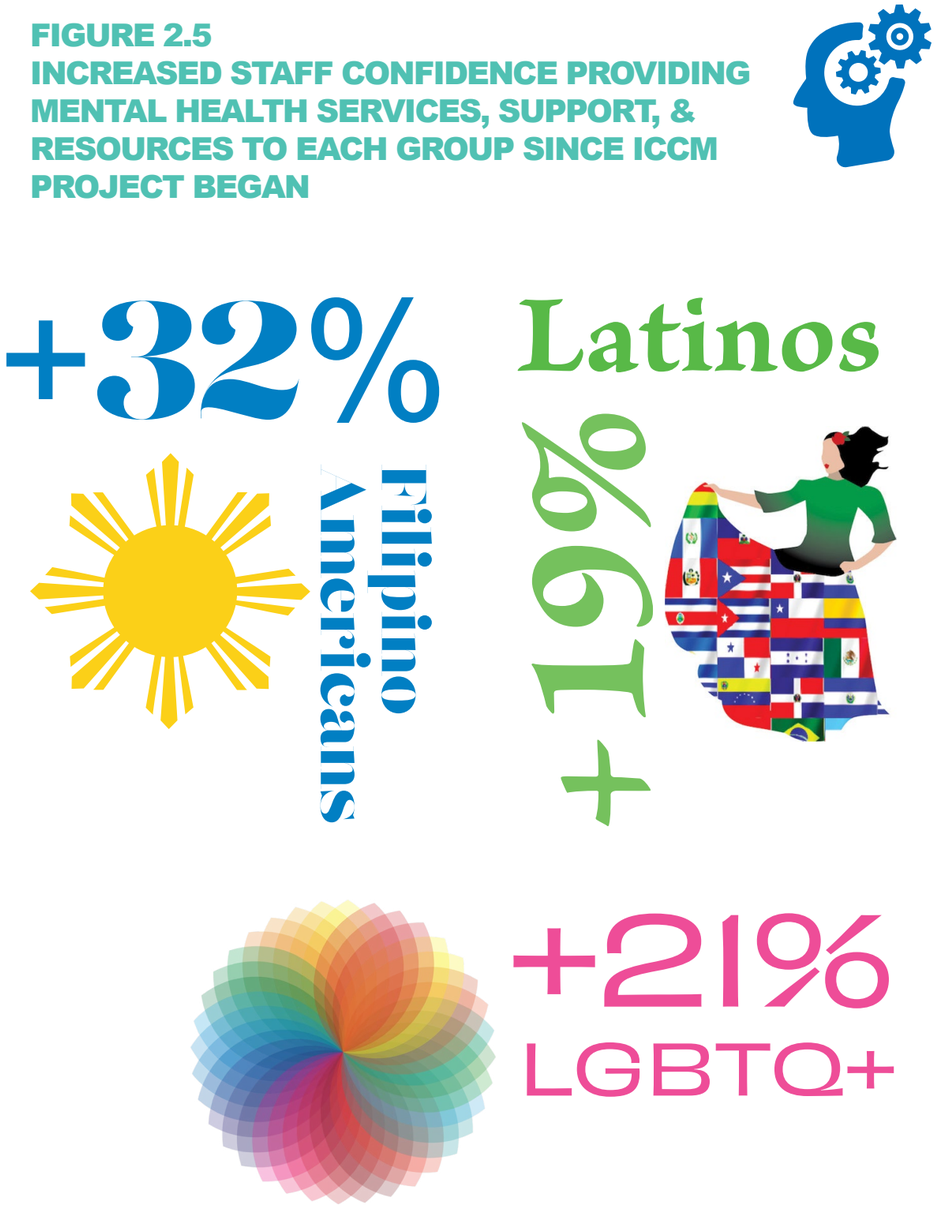
Although confidence increased most in supporting Filipino Americans, the actual overall positive response rate was highest for their confidence in supporting Latinos. This may, in part be to the fact that participants had stronger levels of confidence in working with Latinos before the training (63 percent vs 55 and 44 percent) due to higher levels of engagement with that community prior to the training itself. or the fact that 1 in 4 participants identified as Latino.

Community Engagement

Participants' self-reported level of engagement with the three priority populations are shown in **Figure 2.6**.

Reported engagement with both the Filipino American and LGBTQ+ community was significantly higher at the end of the training and at the 8-month follow-up compared to the pre-training level. As

FIGURE 2.5
INCREASED STAFF CONFIDENCE PROVIDING MENTAL HEALTH SERVICES, SUPPORT, & RESOURCES TO EACH GROUP SINCE ICCM PROJECT BEGAN

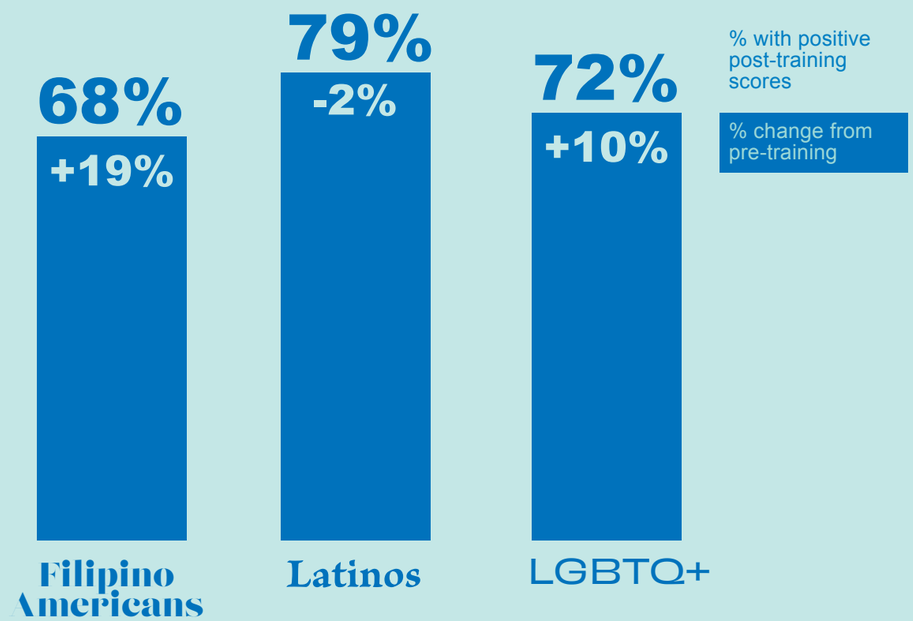


coaching progressed, participants' increased level of engagement with the Filipino American community continued at the post-training level.

Notably, participants reported the highest level of engagement with the Latino community before and after the training, even when considering a slight decrease in the post-training survey as shown in **Figure 2.6**. This may be due to 1 in 4 participants identifying as Latino and thus already having more familiarity and engagement with that community. It is also possible that changes were not detectable due to the small number of training participants.

Improvements across the individual items were greatest with regard to engagement with the Filipino American community. In particular, there were substantial improvements in the frequency by which participants reported that they provided culturally appropriate services to Filipino American community members and within Filipino American communities. Participants were also more likely after the training to report that they provide culturally appropriate services to LGBTQ+ community members.

FIGURE 2.6
STAFF-REPORTED POST-TRAINING COMMUNITY ENGAGEMENT SCORES WITH CHANGE FROM PRE-TRAINING



QUALITY IMPROVEMENT (QI) ACTION PLANS

Ten QI Action Plans were created as part of the CLAS training with several comprised of multiple components within a plan. Below is a list of the names that training participants gave each QI Action Plan. Ten of fifteen CLAS standards will be addressed through the implementation of those QI Action Plans (standards: 2–6, 8–11, 13).

The trainings were able to bring together a total of 12 different types of stakeholders within Solano County, a total of 14 different community organizations and affiliations, 12 different units within SCBH, and 4 Solano County partners, a total of 26 of the 51 participants who completed the training represented one or more of the three communities of focus.

CRHD grouped the QI Action Plans into three areas of focus: Community, Training and Workforce (see **Figure 2.7, next page**).

Community-focused — QI Action Plans containing recommendations prioritized in a way that helps SCBH strengthen community outreach efforts, improve communication regarding resources available and system navigation, and to build better relationships with consumers and community members from the three priority populations throughout Solano County. These QI Action Plans are geared to increasing mental health promotion and wellness and stigma reduction by means of many different venues and strategies.

Workforce-focused — QI Action Plans containing recommendations prioritized to help build a more diverse workforce within SCBH and also to help better prepare the SCBH workforce to provide CLAS informed care. The recommendations in these QI Action Plans are geared to initiate policy changes with Human Resources, and to accommodate numerous career pathways, and to promote systemic workforce involvement with CLAS standards.

Training-focused — QI Action Plans prioritized in a way that helps better train staff members for working with the three communities of focus (with the hope to better prepare them for working with any diverse community).

FIGURE 2.7
QUALITY IMPROVEMENT (QI) ACTION PLANS

COMMUNITY

1. LGBTQ+ Ethnic Visibility
2. Takin' CLAS to the Schools
3. TRUEcare Promoter
4. Bridging the Gap
5. Mental Health Education

TRAINING

1. ISeeU
2. Culturally Sensitive Supervision
3. Cultural Humility Champions

WORKFORCE

1. Cultural Game Changers
2. CLAS Gap Finders

For more information, see report website.

A description of each of the 10 CLAS QI Action Plan is included in Chapter 8 - Sustainability beginning on page 151 of this report. Additionally, a detailed description of each QI Action Plan is outlined in the technical reports which are available on both the SCBH and UCD CRHD website.

SUMMARY AND CONCLUSIONS

The evaluation found that the Providing Quality Care with CLAS Training Program has the potential to improve participants' cultural responsivity and comfort with community engagement.

The ICCTM Project is a model that places great importance on engaging stakeholders collectively who understand the lived experiences of the communities of focus, have strong histories of partnerships with the communities, and take responsibility for developing and supporting mental health services.

In doing so, the ICCTM Project contributes to a collaborative environment in which differing opinions and experiences could be shared, with particular attention made to empower participants, such as consumers and community members, whose voices and perspectives were less commonly heard in mental health settings previously. These conversations helped to develop innovative ideas that were community-defined and practical.

In the end, evaluators found that using community-engagement principles, like what was done in the ICCTM Project, allows for the Providing Quality Care with CLAS Training Program to be customized so organizations can create innovative programs to help reduce mental health disparities in communities of focus.

3

PROVIDER EXPERIENCE

INTRODUCTION

This chapter looks at the experiences of providers, their job satisfaction, and whether job satisfaction differs among providers and non-providers.

A provider is defined as someone who provides direct services or treatment to consumers. A non-provider is someone in support services, administration, leadership, or a volunteer role.

Nine provider satisfaction questions were added to the existing annual Workforce Equity Survey sent to all SCBH employees, as well as to the 29 other agencies, including community-based organizations [CBOs] and/or other County departments/entities receiving funding from SCBH. A total of 284 people responded to the survey and completed at least 1 of 9 job satisfaction items in 2019 & 2020.

METHODS

The SCBH Workforce Equity Survey has been administered annually to staff employed by SCBH and its funded partners since 2017. For the surveys administered in the fall of 2019 and 2020, nine items were added to the annual SCBH Workforce Equity Survey to assess job satisfaction among respondents.

The CRHD evaluation team collaborated with SCBH to examine changes in staff's job satisfaction resulting from the Solano County ICCTM Project

Survey Items/Measures

The nine job satisfaction items were taken from a number of sources including the Job Diagnostic Survey (Hackman & Oldham, 1975) and the Maslach Burnout Inventory (Maslach & Jackson, 1981a, 1981b). Respondents rated all

FIGURE 3.1 PROVIDER EXPERIENCE RESEARCH QUESTIONS

1. **Is participation in the Solano Project associated with higher levels of job satisfaction among SCBH staff?**
2. **Did levels of job satisfaction among SCBH staff differ for providers and non-providers?**

Figure 3.2
Provider Experience Survey Measures

items on a 1 (strongly disagree) to 7 (strongly agree) scale. One of the items (i.e., "I deal very effectively with the problems of my consumers.") also had a response option of N/A "I do not provide direct services," which was treated as missing data in the analysis.

In addition to the nine job satisfaction items, the survey included a number of items that asked about the following demographic characteristics of the respondents: age, gender identity, sexual orientation, race, ethnic identity, whether the individual spoke a language other than English, the languages other than English that the individual spoke, and their position/role. Finally, the survey included the following question to address participation in the training, "Have you participated in the SCBH-UC Davis ICCTM Training Program? (CLAS Training and Coaching Sessions)".

The items were generally positively correlated and the majority of the correlations were statistically significant. Additional statistical analysis revealed the items were measuring two constructs: "General Joy in Work" and "Demonstrating Cultural Humility" as shown **in Figure 3.2**.

Convenience sampling was used to reach and get staff who were available and willing to respond to the survey. This survey technique is affordable and easy to administer when the participants are readily accessible and well-informed of a phenomenon or experience (Cresswell & Plano-Clark 2011).

It is important to point out this type of sampling technique has limitations that include bias due to participant self-selection. As a consequence, results may not be representative of the population of interest (i.e., county staff).

Survey Administration and Response Rates

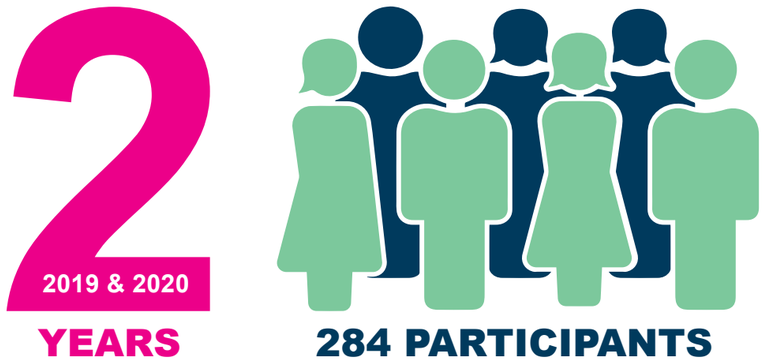
The Workforce Equity Survey was sent to all SCBH employees as well 29 other agencies including community-based organizations [CBOs] and/or other County departments/entities receiving funding from SCBH.

SCBH sent the survey link in an email to all employees as well as to one or more individuals in the contract agency identified as clinical head of service, quality improvement lead, or an office assistant. The contractor contact person then forwarded the email to all their staff asking them to complete the survey.

Description of Survey Respondents

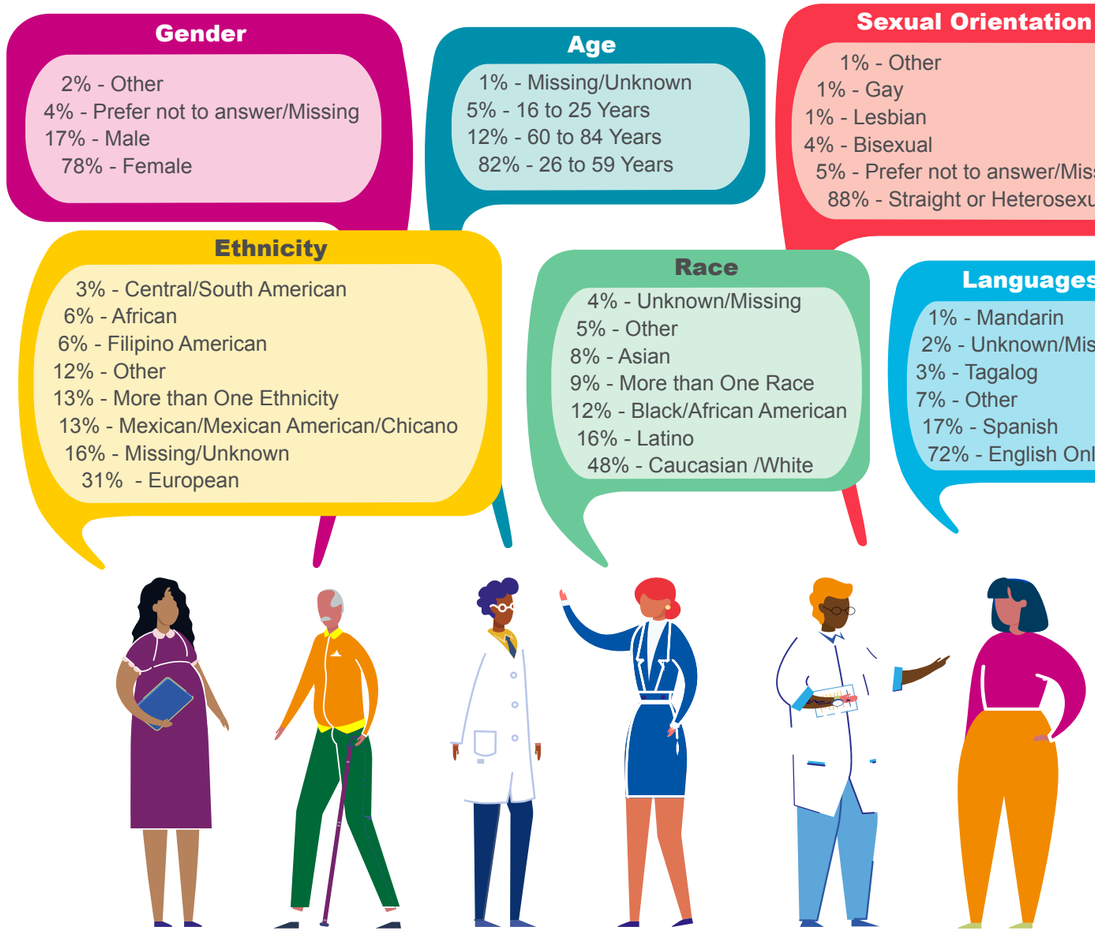
A total of 284 individuals responded to the survey in 2019 and 2020 and completed at least one of the nine job satisfaction items. There were an additional 18 individuals in the data files who responded to the survey but did not complete any of the nine demographic items.

Among the 284 respondents, 58 participated in one of two trainings associated with the ICCTM Project: e.g. "Promoting Cultural Sensitivity in Clinical Supervision" and/or the "Providing Quality Care with CLAS Training" herein referred to as Culturally Sensitive Supervision/ CLAS Training and 208 did not.



A total of 18 respondents with missing data were not included in the analysis. Close to 60 percent of the respondents completed the survey in 2020 compared to just over 40 percent in 2019. All subsequent analyses will combine the two years. The majority of the respondents were between 26 to 59 years old, and female. The majority of the respondents reported they were heterosexual/straight, with a small number of individuals reporting their sexual orientation as bisexual, gay, lesbian, or other. Race, ethnic identity, and other identifying information are included in **Figure 3.3**.

Figure 3.3
Survey Respondents

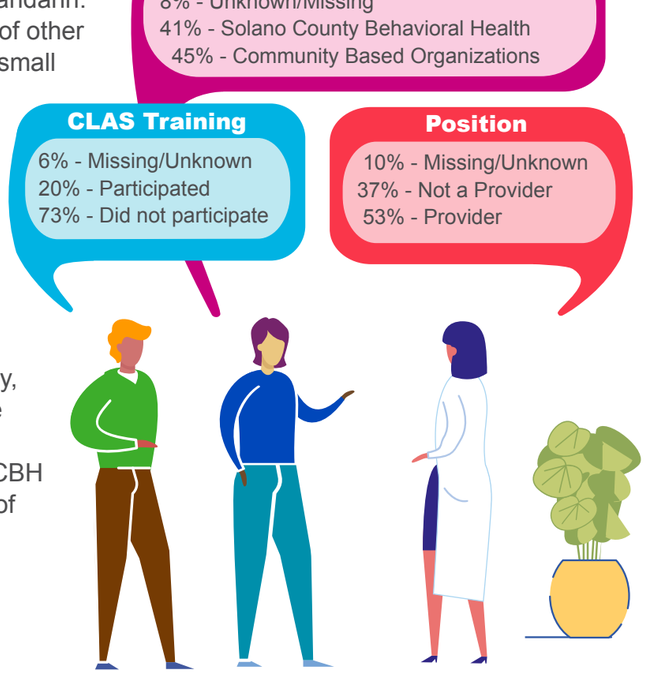


Respondents were racially and ethnically diverse with just over half repporting their race as something other than Caucasian or White. The most common ethnicity reported by respondents was European followed by Mexican/Mexican American/Chicano. Additionally, some respondents reported another ethnicity, such as Puerto Rican or Middle Eastern.

The languages spoken by survey respondents are also shown in **Figure 3.3**. Of those who spoke a language other than English, the most common languages were Spanish, Tagalog, and Mandarin. There were also a range of other languages reported by a small number of respondents, including Cantonese, German, Italian, and Hebrew. A consideration in determining how the survey respondents' language proficiency, cultural competency and diversity mirror the Solano County community, is the core purpose of the annual Workforce Equity Survey and is used by SCBH to inventory the makeup of the workforce on an annual basis.

Figure 3.4 shows the response rate for SCBH employees and the number of responses for CBO agencies, other Solano County Departments, and respondents who did not report their organization. A total of 58 respondents, about 20 percent indicated that they participated in Culturally Sensitive Supervision/CLAS Training.

Figure 3.4
Survey Respondents



Just over half of the respondents indicated that they were providers. This included a range of positions, such as Case Manager/Therapist/Clinician/Psychologist, Medical Support Staff: MA/RN/LVN, Mental Health Specialist/Behaviorist

Support Counselor, Peer Specialist, Peer/Student/Intern Volunteer, Psychiatry Prescribing Staff: PA/NP/MD, and Therapist/Clinician/Psychologist.

Non-providers, such as Board Member, Executive Director/Chief Executive Officer, Manager/Director, Reception/Clerical/Office Support (includes fiscal support), Senior Leadership/Administrator, and Supervisor, represented 37 percent of the respondents.

The demographic data collected through the Workforce Equity Survey is used by SCBH to explore staffing needs, and workforce development practices relevant to all populations served by the County including Latinos, Filipino Americans and LGBTQ+ groups.

Analysis and Reporting

Research Question 1

Is participation in the ICCTM Project associated with higher levels of job satisfaction among SCBH staff?

The data revealed that the majority of all survey respondents expressed a high level of job satisfaction. Agreement with items ranged from 69 to 96 percent (respondents "agreed" or "strongly agreed").

The individuals who participated in Culturally Sensitive Supervision/CLAS Training had slightly higher scores on all nine job satisfaction items than the individuals who did not participate; however, none of the differences were statistically significant.

Research Question 2

Did levels of job satisfaction among SCBH staff differ for providers and non-providers?

Based on this data, it cannot be concluded that the providers and non-providers reported different levels of General Joy in Work or differences in their ability to Demonstrate Cultural Humility.

The percent of providers who agreed with the following statement, "Generally speaking, I am very satisfied with my job," was high at 86 percent, but slightly lower than the 91 percent agreement among non-providers.

The items included in the survey showed good internal reliability. However, there was nearly 100 percent agreement on many of the items which makes it difficult to detect differences between groups.

Staff who did not participate in the training may have learned about the values of diversity, equity and inclusion in the workplace or in other venues, and/or are generally satisfied with their job regardless of trainings made available through SCBH.

Survey results were analyzed by comparing the percent of respondents who agreed or not with each statement and with the two constructions of Joy and Humility.

Independent samples tests were used to assess whether the differences on the nine job satisfaction items across the subgroups of interest were statistically significant.

Furthermore, effect sizes (i.e., a standardized way to measure the impact of a program; Hill et al., 2008) were calculated based on the differences between the groups to help describe the size of the differences.

A pairwise deletion approach was used for the analyses that included respondents that had data for all of the items that were part of each analysis. Evergreen's (2020) recommendations for effective data visualizations were used to inform the development of the graphics in this report.

In addition to the descriptive analyses and the independent samples t tests, multiple regression was used to examine whether the differences between the subgroups were statistically significant after accounting for the other subgroups of interest.

For each of the nine items, survey items were included in a regression model as the outcome measure. Then, participation in training, provider status, and survey year were added as dummy coded predictor variables.

FINDINGS

Findings for Research Question 1

Is participation in the ICCTM Project associated with higher levels of job satisfaction among SCBH staff?

Based on the data, it cannot be concluded that the Solano County ICCTM Project was associated with higher levels of Joy or Humility.

The data did reveal that the vast majority of respondents did express very high levels of Joy in general, as shown in **Figure 3.4.** Nearly every respondent (98 percent) reported that their work they do in their job is very meaningful to them.

The same percent of people also agreed that they had been positively influencing other people through their work.

The items collectively displayed in Figure 3.4 demonstrate that nearly all of the participants, non-providers and providers alike, report high levels of satisfaction or joy in the work that they do.

Similarly, participants also reported high levels of cultural humility with nearly all (98 percent) having a positive attitude toward understanding the health care priorities of the communities they service and then 94 percent have a positive attitude about providing services to underserved groups.

A slightly lower, yet still high, percent of participants reported that they think about what they can do to more effectively interact with underserved minority consumers (89 percent).

Similarly, 88 percent reported that they are in a position to make a difference in the quality of health care that underserved minority consumers receive.

The individuals who participated in Culturally Sensitive Supervision/ CLAS Training had slightly higher scores on all nine job satisfaction items, as well as the summary measures of Joy in Work and Demonstrating Cultural Humility, than the individuals who did not participate.

For all of the items, the differences between the individuals who participated or did not participate in Culturally Sensitive Supervision/ CLAS Training remained nonsignificant when accounting for the respondents' position.

FIGURE 3.4
FINDING JOY IN THEIR WORK

These findings may indicate a need to revise research methods in future projects to determine if participation in Culturally Sensitive Supervision/ CLAS Training consistently has minimal impact on levels of General Joy in Work, or if these results were largely due to research design limitations.

Findings for Research Question 2

Did levels of job satisfaction among SCBH staff differ for providers and non-providers?

The providers had lower scores than the non-providers on six of the nine job satisfaction items but many of the differences were very small and none of the differences were statistically significant.

Providers and non-providers had similar levels of agreement in the two summary measures: General Joy in Work and Demonstrate Cultural Humility as shown in **Figures 3.6 and 3.7.**

The average percent agreement on items measuring Joy in Work was 95 percent for Providers and 94 percent for Non-providers as shown. The differences in agreement were small and further analysis also revealed that there was no statistical significance even when accounting for participation in training.

A similar analysis comparing providers and non-providers and their demonstration of cultural

FIGURE 3.6
AVERAGE PERCENT AGREEMENT ON MEASURES OF JOY IN WORK

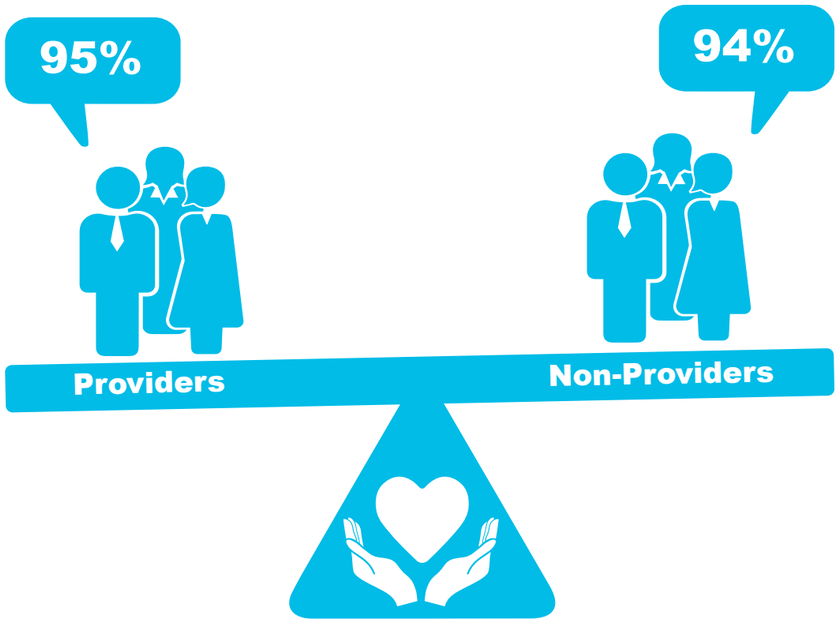
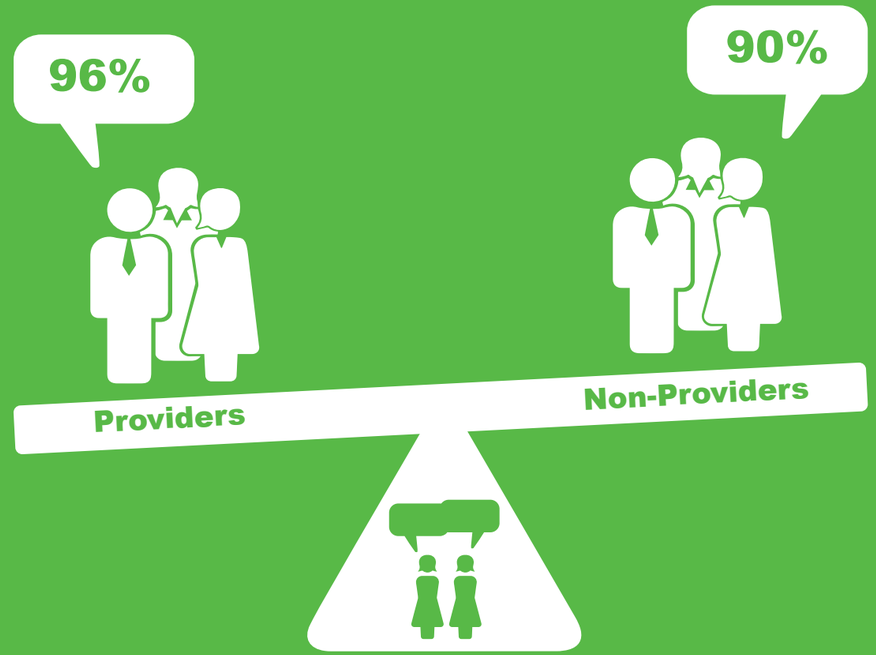


FIGURE 3.7
AVERAGE PERCENT AGREEMENT ON MEASURES OF CULTURAL HUMILITY



humility found no statistical significances. On those measures, the average agreement for providers was 96 percent compared to 90 percent agreement for non-providers as shown in **Figure 3.7**.

CONCLUSIONS AND RECOMMENDATIONS

Overall, the differences between the subgroups of interest (i.e., staff who participated in the training or did not participate in the training and providers and non-providers) were not reliably different. This result could be due to a number of factors.

For example, the nine survey items used to evaluate the potential impact of the Culturally Sensitive Supervision/CLAS Training on staff were part of a larger survey that is administered to all county and partner staff each year.

Respondents were not prompted to recall the training, and among those who recalled participating in training, the experience may have been many months prior to when they completed the survey.

The items included in the survey showed good internal reliability, however, the average ratings on many of the items were approaching 100 percent agreement. When this occurs, it can be difficult to detect differences between groups. Survey items already utilized many of the recommended best practices to avoid ceiling effects (Chyung et al., 2020).

Rather than asking respondents to agree or disagree with specific statements, future surveys could evaluate the frequency with which staff engage in certain behaviors (e.g., once a month or every day). The selection of the correct response options, using that approach could allow the average respondent to be closer to the middle of the response scale.

The similarity in job satisfaction and cultural humility responses between training participants and non-participants could also be due to the fact that staff who did not participate in the training may have been exposed to the values of diversity, equity and inclusion in the workplace or in other venues, and/or are generally satisfied with their job regardless of trainings made available through SCBH.

Studies (e.g., Amo, 2006) have found an association between staff innovative behavior (e.g., knowledge and practices) improving care with clients and working conditions of staff.

When examining the impact of interventions, such as trainings, “contamination” across treatment and control groups can weaken the observed impact of interventions (Hulleman & Cordray, 2009).

While participation in CLAS and cultural sensitivity trainings did not seem to impact job satisfaction and cultural humility, it is important to note that they are still worthwhile and lead to implications for future training and staff development activities.

The research design used for this study also limits the ability to rigorously evaluate the impact of the training on job satisfaction since it was administered only once, after the training (i.e., a posttest only design; Shadish et al., 2002).

Much stronger evidence regarding the impact of the training would result from a research design that surveyed participants and non-participants before and after the training.

As noted above, respondents were not prompted to recall the training as they completed the survey. In the future, in lieu of changing the research design, the items could be modified to ask whether the training made the participants more likely, about the same, or less likely to demonstrate cultural humility (e.g., “devote extra time to the mental health needs of under-served minority consumers”) or ask to what extent the training helped them demonstrate cultural humility.

Based on the survey data, regardless of whether they are providers, staff who participated in Culturally Sensitive Supervision/CLAS Training had the same level of job satisfaction as those who did not participate.

The fact that no differences were found among people who did or did not participate in training does not mean that the training experience is not worthwhile. For future research and evaluations, further exploration of how Cultural Sensitivity Supervision and CLAS Trainings are related to job satisfaction is recommended.

Finally, a qualitative approach could be used to understand the ways that the training impacted participants and led to changes that could improve how the trainings are conducted so that they contribute positively to job satisfaction.

4a

CONSUMER EXPERIENCE: ADULTS

INTRODUCTION

SCBH regularly surveys consumers to evaluate how the Solano County Mental Health Plan (MHP) is meeting their needs.

Survey results were also used as part of the ICCTM Project to develop culturally and linguistically appropriate interventions that positively impact the access and utilization of mental health services for the three communities of focus. Of note, this survey does not collect data for Filipino Americans and LGBTQ+ respondents specifically.

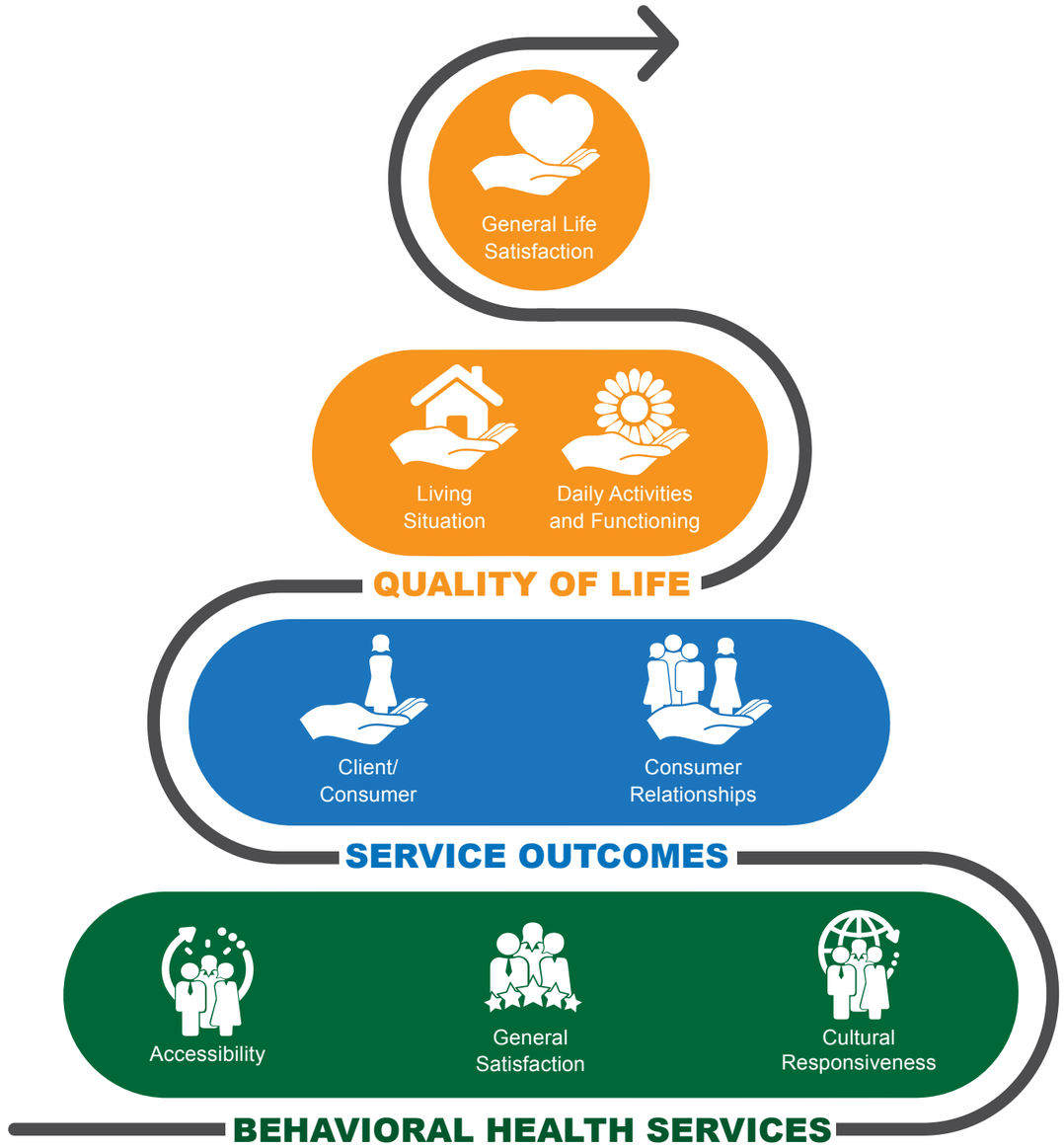
Since the ICCTM Project began in 2016, clients'/consumers' satisfaction with their services increased significantly. The trends across time suggest that implementing the ICCTM Project may have improved perception of the provision of mental health services.

Consumers who were studied as part of the ICCTM Project reported that they were more satisfied with services, had better access to services, and felt that care was more culturally appropriate - as anticipated by the core components of the project.

FIGURE 4.1
CONSUMER EXPERIENCE RESEARCH QUESTIONS

1. What were the clients'/consumers' perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes since the start of the ICCTM Project?
2. Were there differences for the clients'/consumers' perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes?
3. What were the clients'/consumers' perceptions of their Quality of Life in the four years since the start of the ICCTM Project?
4. Were there differences for the clients'/consumers' perceptions of their Quality of Life?

FIGURE 4.2
ICCTM CONSUMER EXPERIENCE MODEL



MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM (MHSIP) CONSUMER SURVEY

SCBH administers the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey to evaluate how the Solano County Mental Health Plan (MHP) is meeting the needs of beneficiaries served.

It is important to note that the MHSIP was developed by the State. Also, the Department of Health Care Services (DHCS) requires that the survey be administered to consumers twice per year.

The MHP includes programs and services delivered by both Solano County and contracted community-based organizations. While one the original goals of the ICCTM Project was to evaluate consumer satisfaction related to the Filipino Americans, Latino, and LGBTQ+ populations in comparison to other groups, the MHSIP survey tool does not currently contain items or questions for a consumer to identify as Filipino American or an LGBTQ+ person.

MHSIP survey results, however, were used to develop culturally and linguistically appropriate interventions that positively impact the access and utilization of mental health services for the three communities of focus through the ICCTM Project.

METHODS

The MHSIP Consumer Survey is administered for one week, twice per year, primarily collected at in-person visits to MHP mental health clinics using a 44 question self-report measure of mental health services.

The survey is administered as a self-reporting tool, and consumers are provided the surveys by reception staff. In the adult clinics, peer-consumer volunteers are present to provide help and support as needed. Surveys are offered in English, Spanish and Tagalog (Solano County's threshold and sub-threshold languages).

Different versions of the survey are administered based on age. This report focused on adults ages 18-59 and older adults ages 60 and over who received mental health services in 2014 through 2020. The survey measured three domains of clients'/ consumers' perceptions of mental health services as shown in **Figure 4.2**.

At the foundation of the model, the first domain measures clients'/ consumers' General Satisfaction with the Services, Accessibility of the Services, and Cultural Responsiveness of the Services. These three constructs are thought

to influence the second domain which measures perception of Service Outcomes for the Consumer and the Service Outcomes for the Client's/Consumer's Relationships. Finally, the third survey domain measures the clients'/consumers' General Life Satisfaction, Quality of Life: Living Situation, and Quality of Life: Daily Activities and Functioning, which are hypothesized to be influenced by the first two domains.

Participants

The survey collects demographic data such as gender, Latino ethnicity, race, and date of birth. Respondents' date of birth was used to calculate age. Consumers were also asked whether they received services in their preferred language. Individual items, are taken from the existing MHSIP Consumer Survey (Eisen et al., 2001) and have been modified slightly to make them more appropriate for Solano County residents.

Between the years 2014 and 2020, a total of 2,423 consumers completed the MHSIP survey. The demographic characteristics of the consumers who completed the survey are shown in **Figure 4.3**. The vast majority of the respondents (2,231) completed the adult survey, and 191 respondents completed an older adult survey.

Since 2014, respondents were slightly more male (45.2 percent) than female and ranged in age from 18 to 90, but were primarily 59 or younger (74.9 percent). Respondents were primarily White (36.0 percent) and Black/African American (21.7 percent), and 17.4 percent reported that they were of Latino ethnicity.

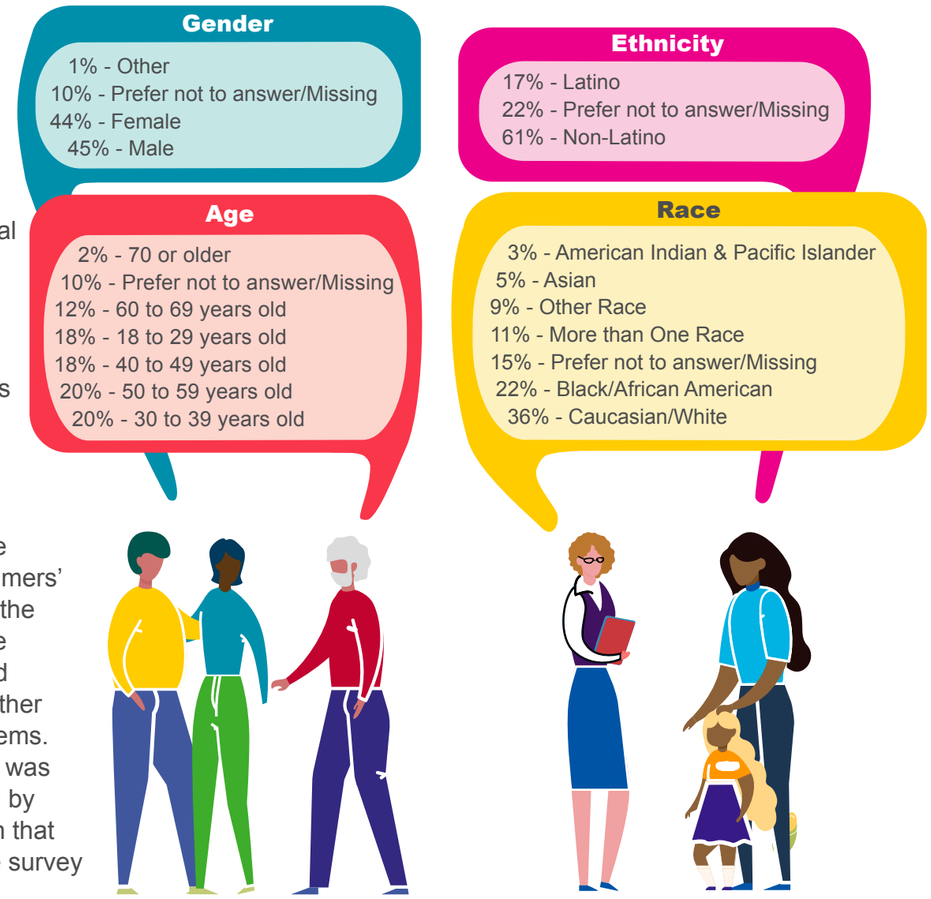
The number of survey responses varied across the years from a high of 512 in 2015 to a low of 108 in 2020. The response rate in general can be attributed to the following: surveys are only collected for office-based services therefore consumers seen in the community or their homes are not administered surveys; and annually the MHP has identified that several programs have failed to participate in the survey collection. The low number of completed surveys in 2020 can be attributed to the COVID-19 pandemic, as offices were closed/ services were limited/there was no survey administration protocol for telehealth services. Additionally, in 2020 the state only required counties to administer one cycle of the MHSIP due to COVID-19.

Survey

The MHSIP Consumer Survey consists of 44 items that assess several aspects of consumers' experience with Solano County MHP's mental health services. To identify the different aspects of the clients'/consumers' experiences, the 44 items were examined and grouped together with similar items. That analysis was also informed by prior research that examined the survey questions (Jerrell, 2006).

Consumers rated their General Satisfaction with the Services, Accessibility of the Services, Cultural Responsiveness of the Services, Service Outcomes for the Consumer, and Service Outcomes for the Client's/Consumer's

Figure 4.3
Survey Respondents



Relationships using the following response options:

- Strongly agree
- Agree
- I am neutral
- Disagree
- Strongly disagree
- Not applicable (which were not included in this analysis)

Consumers reported on their quality of life using the following response options:

- Delighted
- Pleased
- Mostly Satisfied
- Mixed
- Mostly Dissatisfied
- Unhappy
- Terrible

Evaluators used a statistical technique to ensure internal consistency among the eight areas of the ICCTM Consumer Experience Model. Based on that analysis, survey areas with multiple outcomes showed strong reliability, consistency with prior research, and the intent of those developers (Shafer & Ang, 2018).

Analysis

To summarize the clients'/consumers' experiences in the eight areas, the percentage of clients'/consumers' responses were calculated for each of the 44 questions. For the first five domains, the percentages are presented individually for strongly agree, agree, and I am neutral, and combined for disagree and strongly disagree because of the low frequency of responses for these two response options.

Each client's/consumer's responses to the questions with multiple survey items were averaged over years using the strongly agree to strongly disagree scale or the delighted to terrible scale so that each consumer had a single score for each area. The score for Quality of Life: General Life Satisfaction was based on a single item.

Evaluators used a statistical technique known as regression analysis to determine whether the average scores for 2014-2016 differed to a statistically significant extent when compared to the average scores after 2016. That analysis revealed that the pattern of findings was nearly identical whether or not the models controlled for gender, age, race, and ethnicity. As a result, findings presented here do not control for the demographic measures.

FINDINGS

Since 2014, the positive response rates for the first five survey areas that focused on mental health services were high, ranging from 78 to 92 percent agreement. The Solano County results are similar to the findings from other California counties (Health Services Research Center, 2017).

Since the ICCTM Project began in 2016, half of the respondents reported positively with 50 percent reporting they were pleased, delighted or mostly satisfied with their quality of life.

For context, the same survey items were used to measure the average general life satisfaction for a sample of veterans with post-traumatic stress disorder and a group of homeless people transitioning to community living in the Netherlands.

With both comparisons, the consumers in the ICCTM study reported higher levels of general life satisfaction (de Vet et al., 2019).

Findings for Research Question 1

What were the clients'/consumers' perceptions of their General Satisfaction with the Services, the Cultural Responsiveness of the Services, the Accessibility of the Services, and their Service Outcomes in the four years (2017-2020) since the start of the ICCTM Project?

The vast majority of the consumers reported they were generally satisfied with the mental health services in Solano County. Since 2017, 92 percent of respondents strongly agreed or agreed that they liked the mental health services they received.

Additionally, 87 percent strongly agreed or agreed that they would recommend the agency they were receiving services from to a friend or family member, and 85 percent would choose to receive their mental health services from their agency in Solano County even if they had other choices.

Across the items less than six percent of respondents reported negatively on their satisfaction with the services.

A large majority of consumers reported that mental health services in Solano County are accessible. For example, 90 percent strongly agreed or agreed that services were available when it was good for them. Across all items, less than seven percent of respondents reported negatively about the accessibility of the Solano County MHP's services.

After implementing the ICCTM Project, consumers perceived mental health services in Solano County to be culturally responsive. Since 2017, 90 percent of respondents strongly agreed or agreed that they felt comfortable asking questions about their treatment and medication.

Also, 89 percent agreed that staff

respected their wishes regarding the sharing of their treatment information, and 85 percent agreed that staff helped them obtain the information they needed for their illness.

Overall consumer perceptoions of behavioral health services are shown in **Figure 4.4**. Across the 11 items that assessed the cultural responsiveness of services, no more than seven percent of respondents perceived the services negatively.

Findings for Research Question 2

Were there differences across years (2014-2020) for the clients'/consumers' perceptions of their General Satisfaction with the Services, the Cultural Responsiveness of the Services, the Accessibility of the Services, and their Service Outcomes?

Consumers reported higher general satisfaction with the services since the start of the ICCTM. As shown in **Figure 4.4,** the average responses increased in comparison to pre-ICCTM survey results. Although these differences were statistically significant, the improvements were modest. For example, 92 percent of respondents strongly agreed or agreed that they "liked the services" that they received in the post-ICCTM years, a 6 percent increase from pre-ICCTM years. After the start of the ICCTM Project, 86 percent reported that services were more accessible, a 5 percent increase from pre-ICCTM years. Although statistically significant, increases in accessibility were modest.

Increases in consumers' report of strongly agreed or agreed ranged from a two-percentage point increase for the convenience of the location of services to a seven-percentage point increase for their ability to "see a psychiatrist" when they wanted. In the years after the start of the ICCTM Project, consumers reported that the mental health services in Solano County were more culturally responsive. The average responses post-ICCTM were 4 percent higher than the average responses pre-ICCTM.

Although statistically significant, reported increases in cultural responsiveness were again modest. For example, 90 percent of respondents strongly agreed or agreed that they "felt comfortable asking questions about their treatment and medication" in the post-ICCTM years which increased by two percentage points from the pre-ICCTM years.

Respondents generally reported positive perceptions of the impact of their mental health service across years. However, clients'/ consumers' perceptions of their service outcomes after the start of the ICCTM Project were slightly lower to their perceptions of their service outcomes pre-ICCTM as shown in **Figure 4.5** on the next page. Seven out of 10 respondents consistently reported positive perceptions of their service outcomes across all seven years. There were no statistically significant differences found when comparing the individual post-ICCTM years with the pre-ICCTM years.

There were small improvements on four of the sixteen individual items across years but there was slight decrease in agreement on five of the sixteen items. For example, 75 percent of respondents agreed or strongly agreed that they can better control their life or deal with crisis post-ICCTM compared to 73 percent that agreed or strongly agreed in the pre-ICCTM years.

Across the seven years, respondents reported positive perceptions of the impact of their mental health service on their relationships.

FIGURE 4.4
POSITIVE PERCEPTIONS OF BEHAVIORAL HEALTH SERVICES SINCE BEGINNING OF ICCTM PROJECT

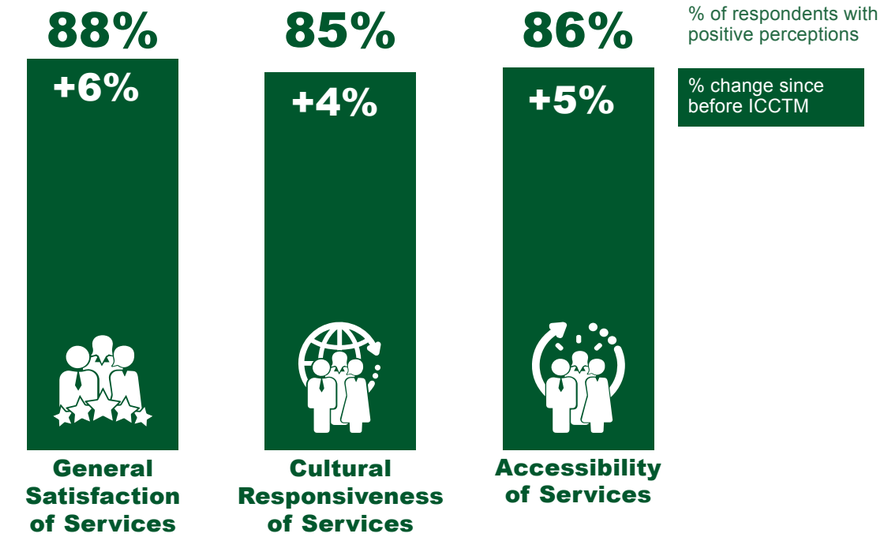
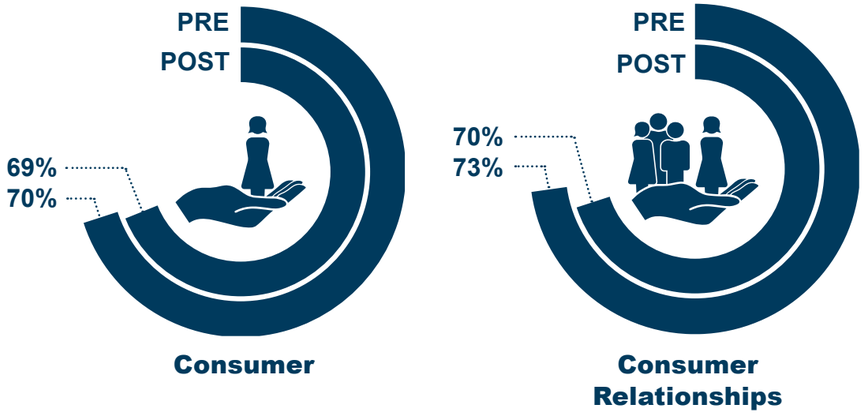


FIGURE 4.5
POSITIVE PERCEPTIONS OF SERVICE OUTCOMES BEFORE AND AFTER THE ICCTM PROJECT



However, as shown in **Figure 4.5**, clients'/consumers' perceptions of their service outcomes on their relationships decreased slightly during the post-ICCTM years.

There were no statistically significant differences in perceptions of service outcomes on relationships since the start of the ICCTM Project. For example, the percentage of respondents who agreed or strongly agreed on relationship items did not change by more than 4 percentage points from pre- to post-ICCTM.

Findings for Research Question 3

What were the clients'/consumers' perceptions of their Quality of Life in the four years since the start of the ICCTM Project (2017-2020)?

Consumers generally reported feeling mostly satisfied with their general quality of life, their living situation, and their daily activities and functioning since the beginning of the ICCTM Project, as shown in **Figure 4.6**.

Since 2017, 50 percent of respondents reported that they were pleased, delighted, or mostly satisfied with their life in general.

Additionally, 60 percent were pleased, delighted, or mostly satisfied with their living situation and 55 percent reported that they were pleased, delighted, or mostly satisfied with daily activities and functioning in their lives.

Findings for Research Question 4

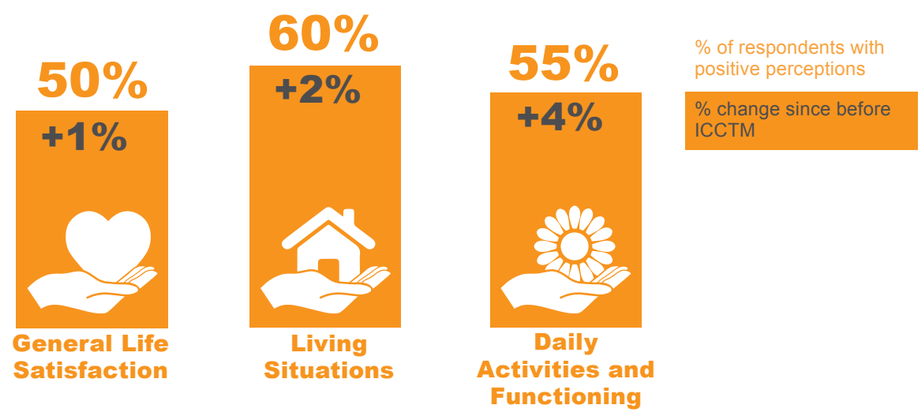
Were there differences across years (2014-2020) for the clients'/consumers' perceptions of their Quality of Life?

Across all years, consumers consistently reported being mixed or mostly satisfied with their general life satisfaction. As shown in **Figure 4.6**, the average for this item ranged from 50 to 60 percent of respondents stating they were "pleased/delighted" or "mostly satisfied." Although the average scores increased in the post-ICCTM years, none of the differences between the individual post-ICCTM years and the pre-ICCTM years were statistically significant.

The difference between the percentage of consumers who reported that they were delighted, pleased, or mostly satisfied with their general life satisfaction in the pre- to post-ICCTM periods amounted to only one percentage point. Across the seven years, consumers reported a consistent level of satisfaction with their living situations and none of the differences were statistically significant.

Across the three items in this domain, there is a three-percentage

FIGURE 4.6
POSITIVE PERCEPTIONS OF QUALITY OF LIFE SINCE THE BEGINNING OF THE ICCTM PROJECT



point difference in the number of consumers who reported that they were delighted, pleased or mostly satisfied with their living situation when comparing the pre- and post-ICCTM periods. Across the individual items, positive response rates ranged from 53 percent to 68 percent.

Consumers reported a consistent level of satisfaction with their daily activities and functioning across the seven years with positive response rates ranging from 45 to 70 percent on individual items. None of the differences between the individual post-ICCTM years and the pre-ICCTM years reached statistical significance.

CONCLUSIONS

The majority of clients'/consumers' had positive experiences with the Solano County MHP's services. Specifically, consumers were generally satisfied with the overall quality of their services, the accessibility of their services, and the cultural responsiveness of their services.

They agreed that their mental health services improved their outcomes and their relationships; and that they were mostly satisfied with their life in general, their living situation, and their daily activities and functioning.

Since implementing the ICCTM Project, clients'/consumers' satisfaction with their services significantly increased from 82 to 86 percent. They also report that they have better access to services and feel that the care is more culturally appropriate.

Based on these findings it appears that implementing the ICCTM Project in Solano County may have improved their perception of the provision of mental health services.

There appears to be minimal improvements in consumers service outcomes and quality of life after the start of the ICCTM Project. Although improvements in these areas may have been expected as a byproduct of improvements in consumer service satisfaction, service outcomes and improvements in quality of life may be more related to external factors not related to service provision.

Quality of Life for consumers who have a serious mental condition is very complex and compounded by many challenges including access to adequate housing, unemployment, discord or estrangement with family and loved ones, financial stressors, co-morbid medical conditions, etc.

Quality of Life for consumers who have a serious mental condition is very complex and compounded by many challenges including access to adequate housing, unemployment, discord or estrangement with family and loved ones, financial stressors, co-morbid medical conditions, etc.

Service outcomes may be less effected by satisfaction consumers feel about their services and more related to external factors or challenges adhering to treatment plans.

Additionally, distal outcomes of the ICCTM Project, like service outcomes and general life satisfaction, may take more time to positively impact.

Since the start of the project, most consumers reported high levels of satisfaction and felt positive about the mental health services delivered by Solano County and contracted community-based organizations.

Clients'/consumers' reported a consistent level of satisfaction with their Quality of Life and Perceptions of Service Outcomes between the pre-ICCTM and post-ICCTM period, one area the program can improve.

Conducting focus groups and interviews with the consumers about their perceived quality of life and service outcomes may provide more in-depth information about these findings. Another opportunity would be to include Filipino American and LGBTQ+ indicators on the MHSIP.

The County should continue providing staff with culturally and linguistically appropriate training to positively impact the access and utilization of mental health services for underserved/underrepresented populations.

IMPLICATIONS

Exploratory analyses showed that Latinos and non-Latinos reported equally high levels of satisfaction with the mental health services, perceptions of their service outcomes, and quality of life in the four years since the start of the ICCTM Project (2017-2020).

Comparisons of the average ratings on the eight survey areas across Latinos and non-Latinos found no differences that were statistically significant. This lack of differences between the groups suggests that the mental health services are meeting the needs of Latinos equally as well as they are meeting the needs of other consumers.

The inclusion of additional demographic questions would allow for a similar examination of whether the mental health services are also meeting the needs of Filipino American and LGBTQ+ populations.

4b

CONSUMER EXPERIENCE: YOUTH

Twice a year, in the Spring and Fall, SCBH administers the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, as required by the Department of Health Care Services (DHCS), to evaluate how the Solano County Mental Health Plan (MHP) is meeting the needs of consumers served.

This chapter examines similar questions as chapter 4a, using the same survey, yet this chapter focuses on the experiences of Solano County youth. Of note, this survey does not collect data for Filipino Americans and LGBTQ+ respondents specifically.

METHODS

The MHSIP Consumer Survey was administered to families and youth for one week, twice per year during in-person visits at Solano County MHP mental health clinics.

The survey is a self-report measure for some youth consumers and other survey results are based on responses by familiy members of youth consumers.

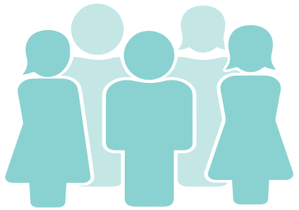
Several additional questions were included in the youth survey that asked about suspensions/ expulsions and school attendance. These additional items were

FIGURE 4.7 CONSUMER EXPERIENCE RESEARCH QUESTIONS

1. What were the families' and youth's perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes in the three years after the start of the ICCTM Project (2017-2019)?
2. Were there differences across years (2014-2019) for the families' and youth's perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes?
3. How many families' and youth's reported experiencing expulsions or suspensions and improved school attendance while receiving mental health services in the three years after the start of the ICCTM Project (2017-2019)?
4. Were there differences across years (2014-2019) for the families' and youth's reports of their expulsions or suspensions and school attendance while receiving mental health services?

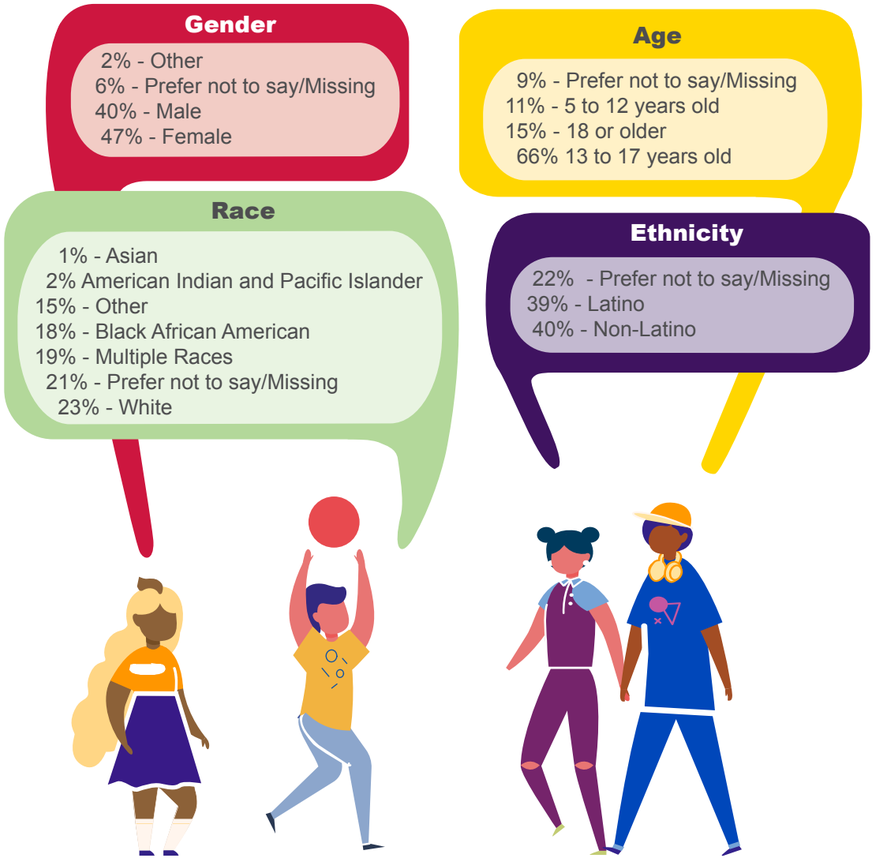
included in the survey and are part of the current analysis. There are also different versions of the survey administered based on the consumer's age. For purposes of this report, we focus on children and adolescents ages 0-18 and their families.

Surveys were administered to 1,106 children/youth and family consumers who received mental health services between 2014 through 2020.



1,106 YOUTH

Figure 4.8
Survey Respondents

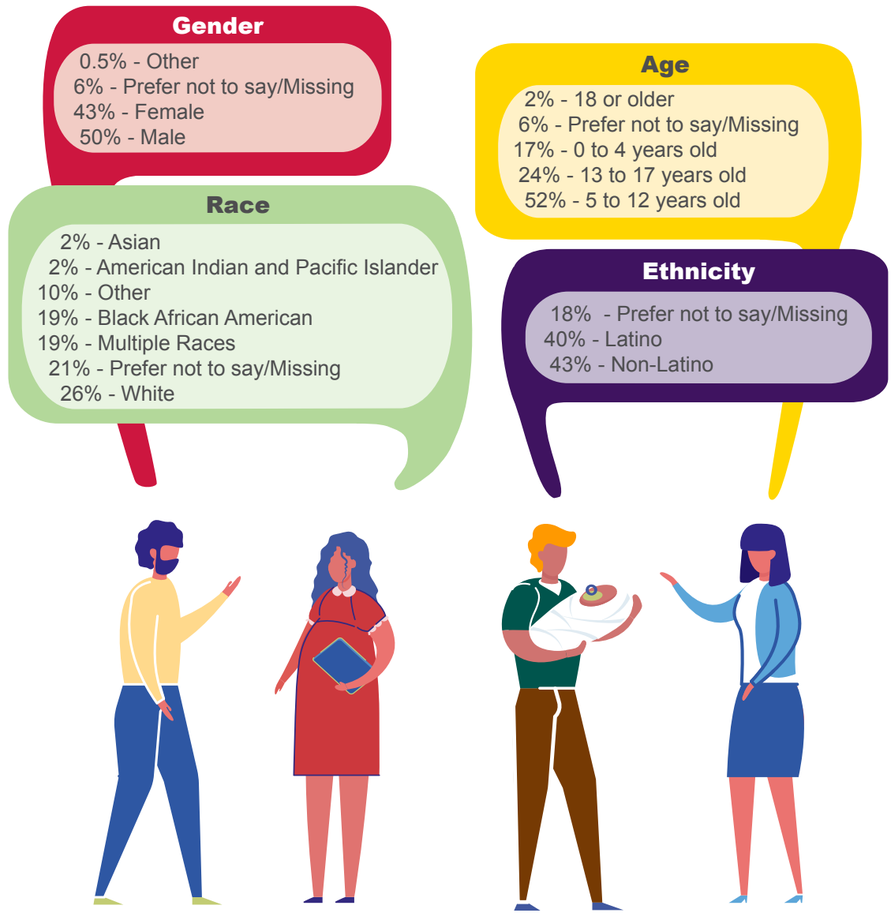


1,866 FAMILY MEMBERS

Participants

Between 2014 and 2020, nearly 3,000 people who received services in Solano County completed the MHSIP Survey, their demographic information is shown below in Figure 4.8.

The Youth Survey was completed by children and teens, reflecting on their own experiences, and the Family Survey was completed by



an adult family member/caretaker, reflecting on their observations of the services received by their youth family member.

Respondents' date of birth was used to calculate their age. They were also asked demographic questions such as their gender, race, and ethnicity, and whether they received services in their preferred language.

The participation rates shown in the figures on the two previous pages provide information about the youth who received the services from SCBH regardless of who completed the survey. More respondents completed the family survey (n = 1,866) compared to the youth survey (n = 1,106). The number of survey responses varied across the years from a high of 636 in 2019 to a low of 85 in 2020.

The low response rate in general can be attributed to the following: surveys are only collected for office-based services therefore consumers seen in the community or their homes are not administered surveys; and annually the MHP has identified that several programs have failed to participate in the survey collection. Given there were less than 50 responses from families and youth in 2020, this year was excluded from the analyses presented in the remainder of this report. The low number of completed surveys in 2020 can be attributed to the COVID-19 pandemic, as offices were closed/services were limited/ there was no survey administration protocol for telehealth services.

From 2014 to 2019, children reported on in the family survey were more likely to be male (50 percent) than female and were primarily 12 or younger (69 percent). In contrast, the respondents who completed the youth survey were more likely to be female (47 percent) and were primarily 13 or older (80 percent). Across the family and youth surveys, nearly 40 percent of the children or youth were Latino. Additionally, the children and youth were racially diverse, with Black/ African American, White, and Multiple Races representing at least 18 percent of the responses.

Survey

The MHSIP Consumer Survey consists of 26 items that assess several aspects of consumers' experience with Solano County MHP's mental health services. To identify the different aspects of the clients'/consumers' experiences, the 26 items were examined using a statistical technique that groups similar items with each other. The analysis was also informed by prior research that examined the survey questions (Jerrell, 2006) and identified five themes or areas that were used for this study:

1. General Satisfaction with the Services
2. Accessibility of the Services
3. Cultural Responsiveness of the Services
4. Service Outcomes for the Consumer
5. Service Outcomes for the Client's/Consumer's Relationships

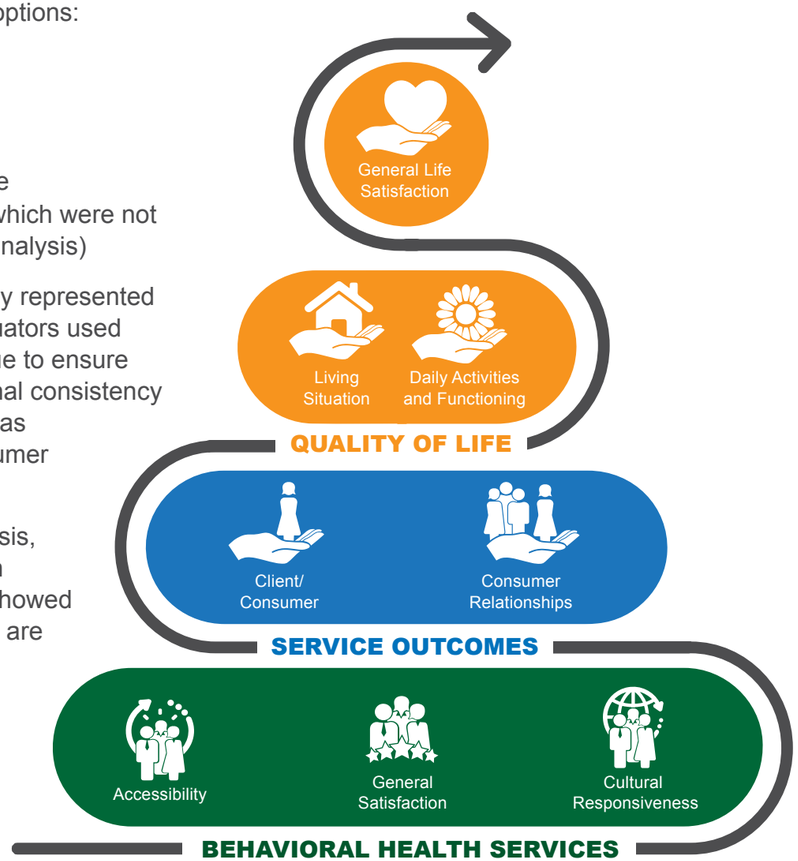
Service Outcomes for the Client's/ Consumer's Relationships used the following response options:

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree
- Not applicable (which were not included in this analysis)

Similarly, to the study represented in Chapter 4a, Evaluators used a statistical technique to ensure that there was internal consistency among the eight areas of the ICCTM Consumer Experience Model.

Based on that analysis, all survey areas with multiple outcomes showed strong reliability and are consistent with prior research and the intent of those developers (Shafer & Ang, 2018).

The family and youth surveys also contained questions that asked whether the child or youth had been expelled or suspended and whether the number of days they were in school (i.e., school attendance) was greater during the last 12 months/year (if they had been receiving services for more than one year) or since beginning services (if they had been receiving services for one year or less).



Data from the items completed by families and youth who had received services for more than one year and families and youth who had received services for less than one year were combined.

As a result, the data presented in the findings should be interpreted as representing the time the families and youth had been receiving services for up to one year. For the school attendance measure, responses of "greater" were coded as "improved" for the analysis. Additionally, responses of "about the same" and "child/I did not have a problem with attendance" before starting services were coded as "stayed the same."

Analysis

To summarize the clients'/consumers' experiences in the five areas, the percentage of clients'/consumers' responses were calculated for each of the 26 questions. Percentages based on the response options are reported for the expulsion/suspension and school attendance items are presented in the findings. Descriptive statistics were calculated based on the survey data, and statistical techniques were used to determine the reliability of the constructs with multiple survey items.

To examine whether there were any differences across years, each client's/consumer's responses to the questions comprising each area with multiple survey items were averaged using the strongly disagree to strongly agree scale. Inferential statistics, including regression analysis and ordinary least squares regression were used to measure statistical significance.

Exploratory analyses did not find significant differences in the data when controlling for gender, age, race, and ethnicity, and therefore the data in this chapter are presented using overall groups responses without subgroup comparisons.

Findings

Since 2014, Family and Youth respondents reported positively on the survey scales that focused on mental health services, with nearly 100 percent of respondents reporting positively on General Satisfaction, Accessibility, and Cultural Responsiveness scales.

The responses from Solano County Family and Youth are similar to the findings from adult respondents in other California counties (Health Services Research Center, 2017). They are also consistent with prior results from other states that showed that parents and youth were satisfied or very satisfied with the services they received from community mental health centers (Martin et al., 2003).

Family respondents reported higher positive responses for these four scales compared to the youths' responses. In contrast, the same percent of Family and Youth respondents reported positively on the Service Outcomes for Consumer scale as shown in **Figure 4.9.**

Research Question 1

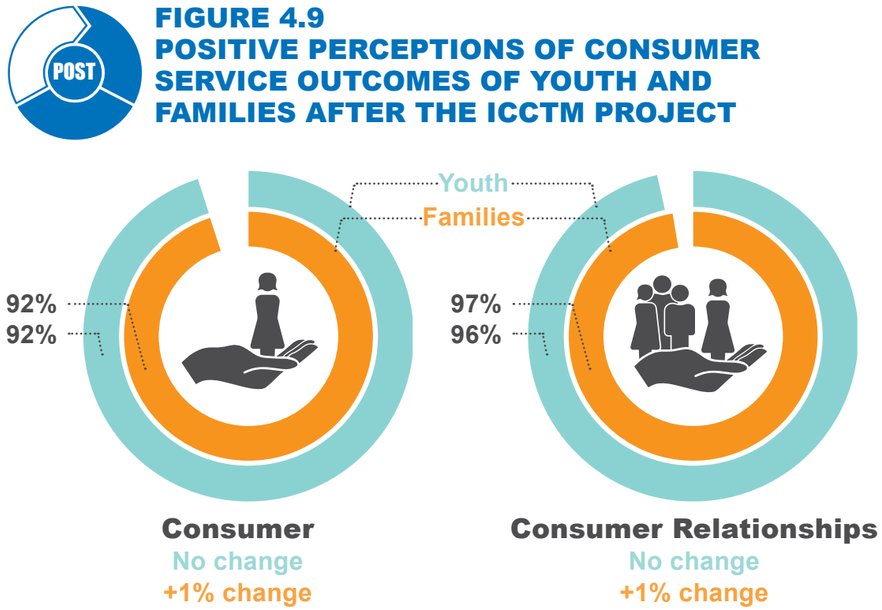
What were the clients'/consumers' perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes in the three years after the start of the ICCTM Project (2017-2019)?

After the start of the ICCTM Project, the vast majority of the consumers reported being generally satisfied with the mental health services in Solano County.

Between 2017 and 2019, 93 percent of families and 92 percent of youth strongly agreed or agreed that they were satisfied with the mental health services they received in Solano County. Additionally, 92 percent of families and 89 percent of youth strongly agreed or agreed that the services they received were right for them.

Finally, 93 percent of families and 87 percent of youth strongly agreed or agreed that there was someone to talk to when experiencing

FIGURE 4.9
POSITIVE PERCEPTIONS OF CONSUMER SERVICE OUTCOMES OF YOUTH AND FAMILIES AFTER THE ICCTM PROJECT



trouble. This is an important finding because it may be showing that families and youth are connecting with someone who is responsive to their needs. Additionally, 95 percent of families and 87 percent of youth strongly agreed or agreed that the services were available at times that were convenient for them.

After implementing the ICCTM Project, consumers perceived mental health services in Solano County to be culturally responsive. From 2017 to 2019, 99 percent of families and 96 percent of youth reported that the staff treated them with respect, 99 percent of families and 97 percent of youth reported that staff spoke to them in a way that they could understand.

However, 97 percent of family members reported that staff were sensitive to their ethnic/cultural background. These differences may be due to youth's understanding of what would constitute as ethic/ culturally sensitive services.

Collectively, since the start of the ICCTM, the vast majority of the youth reported positively about their general satisfaction with services (96 percent), the accessibility of services (97 percent), and the cultural responsivity of services (99 percent). These figures along with the positive perceptions of families are shown in **Figure 4.10**.

From 2017 to 2019, more than half of consumers strongly agreed or agreed that they experienced positive service outcomes.

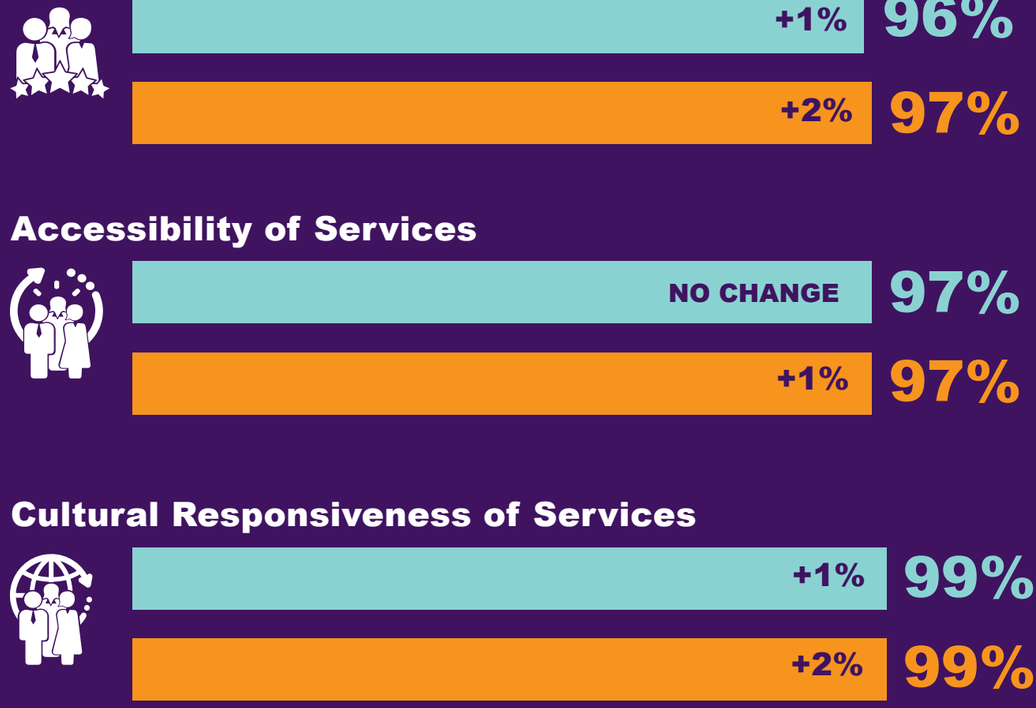
Specifically, youth respondents strongly agreed or agreed that they are better at handling their daily lives (73 percent), get along better with friends or other people (72 percent), and are better able to cope when things go wrong (71 percent).

Additionally, 70 percent of youth family members reported their child gets along better with family members and 67 percent is doing better in school and/or work.

Family members also strongly agreed or agreed that they were satisfied with their family life (66 percent) and that their child is able to do things they want to do (73 percent). Across the service outcomes 8, less than 15 percent of consumers responded negatively about outcomes from mental health services in Solano County.

From 2017 to 2019, most clients experienced positive service outcomes related to their interpersonal relationships: 86 percent of Youth agreeing that they have people with whom they can do enjoyable things, 86 percent who know people who will listen and understand them when they need to talk, and 78 percent who have support from family or friends.

FIGURE 4.10
CHANGE IN POSITIVE PERCEPTIONS OF BEHAVIORAL HEALTH SERVICES BETWEEN YOUTH AND FAMILIES



Youth in blue
Families in orange

Comparison between number of people who agreed or strongly agreed with statements in each domain and subcategory on the Consumer Experience surveys using a weighted average for 2017 through 2019 in comparison to the average of 2014 through 2016.

Family respondents strongly agreed or agreed that they know people who will listen and understand them when they need to talk (92 percent), have people that they are comfortable talking with about their child's problem(s) (94 percent), and would have the support they need from family or friends in a crisis (86 percent).

Across the service outcomes, fewer than 7 percent of consumers responded negatively about mental health services' impact on relationships.

Research Question 2

Were there differences across years (2014-2019) for the families' and youth's perceptions of their General Satisfaction with the Services, the Accessibility of the Services, the Cultural Responsiveness of the Services, and their Service Outcomes?

Families reported consistently high general satisfaction with the services from 2015 through 2019. There was no clear trend showing differences in the post-ICCTM period and none of the differences between the post-ICCTM years and the pre-ICCTM Project period reached statistical significance.

However, 97 percent of youth and 97 percent of families reported positively about accessibility stating that times and locations were convenient since ICCTM began.

As shown in **Figure 4.11** are high positive perceptions were reported for cultural responsiveness with 99 percent of respondents stating that staff treated them with respect and 97 percent of youth and 98 percent of families saying that staff were sensitive to their culture/ethnicity since ICCTM began.

Youth reports of their general satisfaction with the services increased slightly in 2017 after the start of the ICCTM Project. Although the percent of people responding positively were higher in each of the post-ICCTM years compared to the pre-ICCTM Project period, the gradual increases only reached statistical significance in 2019.

Since ICCTM began, 97 percent of youth and 98 percent of families were satisfied overall and also received services that were right for them as shown in **Figure 4.11.**

Although there was a trend showing improvements and one statistically significant difference, the increases in general satisfaction were modest. The improvements resulted from comparatively more youth strongly agreeing than agreeing with the statements in the post-ICCTM Project period.

For example, 55 percent of youth strongly agreed that they were satisfied with the services they

FIGURE 4.11
PERCEPTIONS OF BEHAVIORAL HEALTH SERVICES BETWEEN YOUTH AND FAMILIES

% of Youth or Families who agreed with each statement

ACCESSIBILITY

"TIMES were convenient"
96/97%

"LOCATIONS were convenient"
97/97%

CULTURAL RESPONSIVENESS

"treated me with RESPECT"
99/99%

"sensitve to my CULTURE/ETHNICITY"
97/98%

SATISFACTION WITH SERVICES

"overall, i am SATISFIED"
97/97%

"received services that were RIGHT FOR ME"
97/98%

received in the post-ICCTM period compared to 43 percent of youth in the pre-ICCTM Project period.

On average families agreed that Solano County mental health services were accessible during the pre- and post-ICCTM Project periods.

There were no clear trends showing differences in the post-ICCTM period and none of the differences between the post-ICCTM years and the pre-ICCTM period reached statistical significance. At the same time, 97 percent of families strongly agreed or agreed that the location of services were convenient for them in both the post-ICCTM and pre-ICCTM Project periods.

Differences between the pre- and post-ICCTM Project years were modest. For example, 87 percent of youth strongly agreed or agreed that the location of the services was convenient in 2014 through 2016 and 90 percent of youth strongly agreed or agreed with the same statement in 2017 through 2019.

Families had consistently positive perceptions of the cultural responsiveness of the services from 2014 through 2019 with average positive responses ranging from 98 to 99 percent for the four items in that construct.

Overall, youth reported more positive perceptions of the cultural responsiveness of the services they received from the pre- to post-ICCTM Project period.

Across the pre- and post-ICCTM Project years, families reported fairly positively on their service outcomes. Families reported similar perceptions of service outcomes pre- to post-ICCTM Project. For example, 71 percent of families reported that their child is better at handling daily life in the pre-ICCTM Project period compared to 68 percent of families in the post-ICCTM Project period.

Similarly, 70 percent of families strongly agreed or agreed that their child gets along better with friends and other people pre-ICCTM Project compared to 69 percent of families agreeing (strongly agreed or agreed) post-ICCTM Project.

Youth reported similar perceptions of service outcomes pre- to post-ICCTM Project. For example, youth reported similarly positive perceptions on whether they were better able to do things they want to do during the pre-ICCTM Project (69 percent) and post-ICCTM Project (68 percent) period.

Youth also increased in their positive perceptions that they were better at handling daily life at the time of the survey from pre-ICCTM (70 percent) to post-ICCTM Project (73 percent). Notably, many youth reported that they were undecided about their service outcomes (between 20 and 27 percent).

Across the pre- and post-ICCTM Project years, families reported positively on the impact of their service outcomes on their relationships.

For example, most families reported that they know people who will listen and understand them when they need to talk at the same rate during the pre-ICCTM period compared to the post-ICCTM Project period (92 percent).

Similarly, 92 percent of families strongly agreed or agreed that they have people that they are comfortable talking with about their child's problem(s) pre-ICCTM compared to 94 percent of families agreeing post-ICCTM Project.

Over the pre- and post-ICCTM Project years, youth reported a positive impact of their service outcomes on their relationships. Youth reported similar perceptions of service outcomes which showed no significant difference from pre- to post-ICCTM Project years.

For example, most youth similarly reported that they know people who will listen and understand them when they need to talk in the pre-ICCTM period (87 percent) compared to the post-ICCTM Project period (86 percent).

Similarly, 84 percent of families strongly agreed or agreed that they have people that they are comfortable talking with about their problem(s) pre-ICCTM compared to 82 percent of youth agreeing post-ICCTM Project.

It is also worth noting that when comparing Latino with non-Latino youth and families, both groups reported positively on the five survey scales that focused on mental health services, Both groups had high levels of satisfaction with the mental health services and positive perceptions of the Service Outcomes for Consumer

Research Question 3

How many families' and youth's reported experiencing expulsions or suspensions and improved school attendance while receiving mental health services in the three years after the start of the ICCTM Project (2017-2019)?

In the three years after the start of the ICCTM, 11 percent of families reported their child had been expelled or suspended while receiving mental health services in the prior year, and 15 percent of youth reported that they had been expelled or suspended while receiving mental health services in the prior year as shown in **Figure 4.12.**

These results suggest youth receiving mental health services in Solano County were

FIGURE 4.12
SCHOOL OUTCOMES AS REPORTED BY YOUTH AND FAMILIES

SUSPENDED OR EXPELLED FROM SCHOOL

IMPROVED ATTENDANCE IN SCHOOL

Youth in blue

Families in orange

disproportionately experiencing difficulties that may have impacted their behavior in school.

According to data from the California Department of Education, Solano County's expulsion rate was below one percent and the suspension rate was approximately six percent between the 2016-17 and 2018-19 academic years (California Department of Education, 2021).

Given the population the Solano County MHP serves, consumers with more severe mental health conditions, findings should be interpreted with caution when comparing to all students in Solano County. Although it is expected that mental health services would have a positive impact on youth behaviors in school, school disciplinary outcomes are impacted by several structural and interpersonal factors (Cruz et al., 2018; Huang et al. 2018).

Of note, 24 percent of families reported their child's school attendance improved while they were receiving mental health services in the prior year and only seven percent indicated their child's school attendance declined while receiving services in the prior year. As shown in **Figure 4.12** on the previous page, 30 percent of youth indicated their school attendance improved while they were receiving mental health services.

School attendance is not a common issue for all adolescents and youth. Therefore, small increases or decreases may be representative of a small sample of students.

Prior research has found that school absences may be less impacted by mental health services, and may be more associated with socioeconomic factors (e.g., illness, family context, housing stability) that may not be addressed by mental health services (Kang-Yi et al., 2018).

Research Question 4

Were there differences across years (2014-2019) for the families' and youth's reports of their expulsions or suspensions and school attendance while receiving mental health services?

Families' reports of expulsions and suspensions fluctuated between 2014 through 2019. The percentage from 2019 (i.e., nine percent) was lower than the percentage from the pre-ICCTM Project period (i.e., 15 percent) and this difference was statistically significant. The percentage from 2016 (i.e., 18 percent) was noticeably higher than the other years.

With the exception of 2016, the percentage of youth reporting they were expelled or suspended ranged from 14 to 16 percent. There was no clear trend showing improvements in the post-ICCTM Project period and

none of the differences between the post-ICCTM years and the pre-ICCTM Project period (i.e., 18 percent) reached statistical significance.

The percentage of families reporting improved school attendance fluctuated somewhat across years and ranged from a low of 20 percent in 2016 to a high of 29 percent in 2014.

However, there was no clear trend showing more improvements in attendance during the post-ICCTM period and none of the differences between the post-ICCTM Project years and the pre-ICCTM Project period reached statistical significance. Across the pre-ICCTM period, 23 percent of families reported improved school attendance.

Additionally, 11 percent of Latino youth/families reported expulsions or suspensions while receiving mental health services compared to 13 percent of non-Latino youth/families. Finally, 25 percent of Latino youth/families reported improved attendance compared to 27 percent of non-Latino youth/families.

CONCLUSIONS

Data collected from the MHSIP show that the majority of clients'/consumers' have had positive experiences with the Solano County MHP's services.

Specifically, youth and their families rated that they were generally satisfied with the overall quality of their services, the accessibility of their services, and the cultural responsiveness of their services.

Youth and their families agreed that their mental health services improved their outcomes and their relationships. Since implementing the ICCTM Project, families' and youth's satisfaction with their services remained fairly positive.

Particularly, clients'/consumers' general satisfaction with their mental health services, the accessibility of services, and the cultural responsiveness of services remained high.

Significant increases in youth and families' report of cultural responsiveness after the implementation of the ICCTM Project suggest that the program was effective in improving the cultural appropriateness of the mental health services in Solano County.

Given the core components of the ICCTM Project (community-engaged research, CLAS standards, QI Action Plans), it was expected that the provision of mental health services would be improved.

There appears to be minimal improvements in consumers service outcomes and improvements in quality of life may be more related to external factors not related to service provision.

Quality of Life for child/youth consumers who have a serious mental condition is very complex and compounded by many challenges including social deficiencies, trauma, discord with peers and family, difficulties learning as a result of their mental health condition, etc.

Service outcomes may be less influenced by satisfaction consumers feel about their services and more related to external factors or challenges adhering to treatment plans. Additionally, distal outcomes of the ICCTM Project, like service outcomes, may take more time to for the program to positively impact.

IMPLICATIONS

Exploratory analyses showed that families and youth who were Latinos and non-Latinos generally reported equally high levels of satisfaction with the mental health services and perceptions of their service outcomes in the three years after the start of the ICCTM Project (2017-2019).

Additionally, Latinos and non-Latinos reported similar levels of expulsions or suspensions and school attendance while receiving mental health services in the three years after the start of the ICCTM Project (2017-2019).

We compared the responses on the seven survey areas across Latinos and non-Latinos and only one of the differences was statistically significant. The one statistically significant difference showed that Latinos reported slightly better service outcomes compared to non-Latinos .

The general lack of differences between the groups suggests that the mental health services are meeting the needs of families and youth who are Latino equally as well as they are meeting the needs of non-Latinos.

The inclusion of an additional demographic questions that ask the families and youth whether they are Filipino Americans or identify as LGBTQ+ would allow for a similar examination of whether the mental health services are also meeting the needs of these populations.

5a

HEALTH OUTCOMES: ACCESS TO COUNTY SYSTEMS OF CARE

The **Health Outcomes Summary Chapter 5a** evaluates the impact of the ICCTM Project on access to and timeliness of care using data from the SCBH Division's Access Line, the primary access point for consumers to initiate treatment through the county system of care.

In the context of the ICCTM Project, both Access Line use and timeliness of services improved for all three communitiesof focus. Overall, community-engaged efforts to bolster the delivery of culturally and linguistically appropriate services represents a promising strategy for enhancing the quality and utilization of behavioral health services.

ABOUT THE SCBH ACCESS LINE

The SCBH Access Line is open to callers 24/7 and provides multiple services as shown in **Figure 5.1**. During business hours, the Access Line is answered by county clinicians. After-hours and on weekends the Access Line is answered by staff from the Crisis Stabilization Unit.

Access Line representatives greet the caller and first determine whether they are experiencing an emergency requiring an immediate response. Non-urgent callers undergo an initial screening, lasting 20-30 minutes, to collect demographic information (e.g.,

FIGURE 5.1
SCBH ACCESS LINE

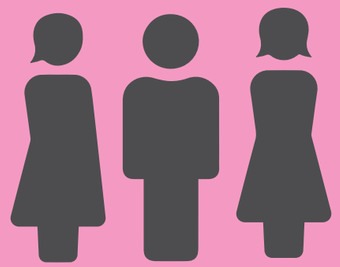
- **Screening for mental health**
- **Screening for substance use treatment**
- **Schedule/arrange intake assessment**
- **Referral to other agency**
- **Referral back to private insurance if available**

WHY DO WE NOT DO A LGBTQ+ VS. NON-LGBTQ+ COMPARISON?

The experiences of transgender individuals in healthcare are markedly different from those of cisgender lesbian, gay, bisexual, and other queer individuals. Combining them may be viewed as erasure of trans experiences. Furthermore, it has been widely understood that in research, these groups should not be combined. Sexual orientation and gender identity are different concepts. And even in recent events, their different experiences in healthcare have been part of headlines. For example, the Trump Administration notably curtailed protections for transgender individuals in health care.

SEXUAL ORIENTATION AND GENDER IDENTITY EXPLAINED

Sexual orientation comprises three things, a person's sexual identity, sexual preferences, and sexual behavior. These three parts make up one's "sexual orientation." The terms "lesbian, gay, bisexual, etc." are actually sexual identities. In the same way that "man" "woman" "transman" "transwoman" "genderqueer" "nonbinary" are gender identities.



Why do we have to separate LGBTQ+ into LGBQ+ & Non-Cisgender Individuals?

The LGBTQ+ acronym includes groups of individuals from both sexual minorities and gender minorities. One's sexual orientation and gender identity are not mutually exclusive. For example, an individual can be transgender as well as lesbian or gay.

Consequently, the L-G-B-T-Q identities are captured by two separate questions:

1. What is your sexual orientation? = Heterosexual, Lesbian, Gay, Bisexual, Queer, Questioning, etc.
2. What is your gender identity? = Male, Female, Transmale, Transfemale, Genderqueer, Two Spirit, etc.

And because these identities are captured by two questions, that's why we report on two types of comparisons in our health outcomes analyses:

1. Non-LGBQ+ (Heterosexual) vs. LGBQ+ (Lesbian, Gay, Bisexual, Queer, Questioning, another sexual orientation)
2. Cisgender (Male or Female) vs. Non-Cisgender (Transgender, Genderqueer, 2 Spirit, Questioning, another gender identity); note that because the number of non-cisgender consumers was so small, the non-cisgender community is not specifically represented in some figures or graphics throughout this ICCTM Report.

race/ethnicity, language, sexual orientation, gender identity, etc.), insurance information, and current mental health symptoms.

Callers who are found to have private insurance are referred back to their insurance carriers. For individuals who have Medi-Cal, Medicare or are uninsured, the clinician will conduct a screening. After the screening, Access Line representatives determine what system of care would be most appropriate for referral, such as assessment for mental health or substance use treatment from a SCBH program, or referral to another entity such as Beacon for individuals who are determined to be mild-to-moderate cases. For those determined to qualify for MHP services, the caller is then offered a date for an intake assessment with a county provider.

This evaluation focuses on the accessibility and timeliness of services for consumers using the Access Line before and during the ICCTM period by addressing six Research questions as shown in **Figure 5.2.**

METHODS

The intake assessment offer and the date of assessment

FIGURE 5.2
HEALTH OUTCOMES RESEARCH QUESTIONS

1. How many consumers use the Access Line and did the number of users increase in the period following the ICCTM Project and overall for the three communities of focus?
2. Did the average number of business days between contacting the Access Line to being offered an intake assessment appointment decrease (improve) in the period following the ICCTM Project and overall for the three communities of focus?
3. What proportion of callers were offered an intake assessment date that met the state-required quality benchmark of being within 10 business days or less of the request for service through the Access Line for the three communities of focus?
4. Did the mean duration (number of calendar days) between contacting the Access Line to starting an assessment appointment decrease (improve) for the three communities of focus in the period following the implementation of the ICCTM Project?

appointment are recorded in the SCBH electronic health record (EHR) through a form called the Access Screening Tree. The quality benchmark pertaining to Access Line timeliness used for this analysis was that callers must be offered an appointment within 10 business days or less per state regulations (SCBH, 2021b).

MEASURES

1. Number of Access Line Users overall and among the three communities of focus
2. Time to Intake Assessment Appointment Offer is the number of days between the date of call requesting service and the date an intake assessment appointment was offered with a quality benchmark within 10 business days

ANALYSIS

Trends in access and timeliness were examined by fiscal year and by comparing pre-ICCTM to the time ICCTM period. To examine the potential influence of the ICCTM Project on the utilization of Access Line services over fiscal years among these communities of focus, time periods were defined as follows:

- Pre-ICCTM: July 1, 2014 through June 30, 2017 - includes fiscal years 14-15, 15-16, and 16-17
- ICCTM Period: July 1, 2017 through June 30, 2020 - includes fiscal years 17-18, 18-19, and 19-20

To make comparisons between Pre-ICCTM, ICCTM, and COVID-19 periods, evaluators assessed the utilization of Access Line services over quarters. The ICCTM period was re-categorized as July 1, 2017 through December 1, 2019. And the COVID-19 period was defined as January 1, 2020 through September 20, 2020.For the purposes of this report when analyzing data related to race and ethnicity, white consumers were used as the reference/comparison group when looking at access timeliness for Filipino American or Latino consumers.

When analyzing data related to sexual orientation and access timeliness non-LGBQ+ consumers were used as the reference/ comparison group and when analyzing data related to current gender identity and when analyzing data related to gender, cisgender consumers were used as the reference/comparison group.

System Considerations Impacting Findings

It is noteworthy that, in 2018, SCBH fully implemented “open access” for the adult system of care, whereby consumers were encouraged to drop into one of the three clinics at their convenience on the day of calling the Access Line, or on the following day, in order to receive an intake appointment. This improved timeliness overall.

Findings related to the offered appointments may be less influenced by demographics of the caller. For the children’s system of care, when there is a call to the Access Line for a child or youth who is screened and eligible for the assessment through the MHP, an appointment is offered with a county clinician within 10 business days. With regard to having the actual assessment appointment, this outcome may have been more influenced by demographics.

RESULTS

Overall, the number of Access Line users steadily increased from an average of 1,601 callers per year in the 3 year period before the ICCTM Project (FY 14-15 through FY 16-17) to 2,066 callers per year in the 3 year period since the ICCTM Project (FY 17-18 to FY 19-20) as shown in **Figure 5.3** on the next page.

Research Question 1

How many consumers use the Access Line and did the number of users increase in the period following the ICCTM Project and overall for the three communities of focus?

The number Access Line callers increased annually for all of the communities of focus. In part this was driven by a change in practices whereby data collection methods improved during the ICCTM period.

The total number of callers increased for all three communitiesof focus with Filipino American’s increasing 32 percent (from 127 to 168 callers); Latino’s increasing 41 percent (from 936 to 1,317 callers; LGBQ+ callers increasing 309 percent (from 121 to 495 callers); and non-cisgender callers increasing 165 percent (from 17 to 45 callers).

The proportion of callers who were Filipino American or Latino increased only slightly. In the pre-ICCTM period, 19 percent of callers were Latino compared to 21 percent in ICCTM period. The number of callers who are Filipino American remained small, although their proportion also increased slightly in the ICCTM period from 2.6 to 2.7 percent.

In addition to looking at the communities of focus, the results

FIGURE 5.3
ACCESS LINE CALLS INCREASED 29 PERCENT SINCE ICCTM BEGAN

% change in Access Line calls and total number of Access Line calls per year since ICCTM began

for all race/ethnicity groups except Black callers were significantly higher when compared to the White race/ethnicity group. These trends did not appear to vary by the pre-ICCTM, ICCTM period, or during the COVID time periods.

Both the number and the proportion of Access Line callers who identified their sexual orientation as LGBQ+ (lesbian, gay, bisexual, queer, questioning, or another sexual orientation) has increased annually. In the pre-ICCTM period, about 40 callers per year identified as LGBQ+.

Beginning in FY 17-18, the number of LGBQ+ callers increased four-fold, with an average of 165 per year. Relative to the proportion of non-LGBQ+ callers, those identifying as LGBQ+ in the pre-ICCTM years was about 2.5 percent compared to almost 8 percent in the ICCTM period.

The increase in Access Line users identifying as LGBQ+ over time was statistically significant. It is important to note that SCBH added the sexual orientation field to their EHR in March of FY 15-16 and subsequently implemented several processes to capture sexual orientation data for existing for consumers. By time period, there were no significant changes over time during the pre-ICCTM, ICCTM, or COVID-19 time periods.

Both the number and proportion of Access Line callers who identified as non-cisgender has increased annually. In the pre-ICCTM period, about 6 callers per year identified as non-cisgender, including transgender, genderqueer, questioning, two-spirit, or individuals of another identity.

Beginning in FY 17-18, the number of non-cisgender callers increased slightly to 12 callers per year in the ICCTM period. Regarding the proportion of non-cisgender Access Line callers, those identifying as non-cisgender was 0.3 percent in the pre-ICCTM period and 0.7 percent in the ICCTM period.

The increase in Access Line users identifying as non-cisgender over time as not statistically significant. As with LGBQ+ callers, it is important to note that SCBH added broader gender identity responses to their EHR in March of FY 15-16, and subsequently implemented several processes to capture gender identity data for existing consumers. By time period, there were no significant changes over time during the pre-ICCTM, ICCTM, or COVID-19 time periods.

Research Question 2

Did the average number of business days between contacting the Access Line to being offered an intake assessment appointment decrease (improve) in the period following the ICCTM Project and overall for the three communities of focus?

Overall, the amount of time between calling the Access Line and being offered an intake assessment appointment decreased (improved) over time from an average of 8 business days in the 3-year period before the ICCTM Project (FY14-15 to FY16-17) to 5 business days in the 3-year ICCTM Project period (FY17-18 to FY19-20).

The proportion of Access Line callers who were offered intake assessment appointments within the timeliness quality benchmark of 10 business days improved.

For Filipino American, Latino , and LGBAccess Line users, the mean number of business days between calling and being offered an intake assessment decreased (improved) over time, see **Figure 5.4.**

The overall trend to offer more timely appointments did not eliminate gaps across racial and ethnic groups. Among Access Line users who identified as White, the mean number of business days to obtain an offered intake assessment decreased from 7.5 days before ICCTM to 4.8 days since the ICCTM Project began.

For most fiscal years, the mean number of business days to obtain an offered intake assessment was significantly greater among Latino users compared to White Access Line users averaging 1 day more in the pre-ICCTM period and 3 days more in the ICTTM period.

In FY 19-20, Latino callers obtained an offered intake assessment up to 2 to 3 business days later than White callers. A potential explanation for this finding is that the mean number of business days to obtain an intake assessment appeared to decrease over time among White Access Line users at a greater rate than that of Latino Access Line users.

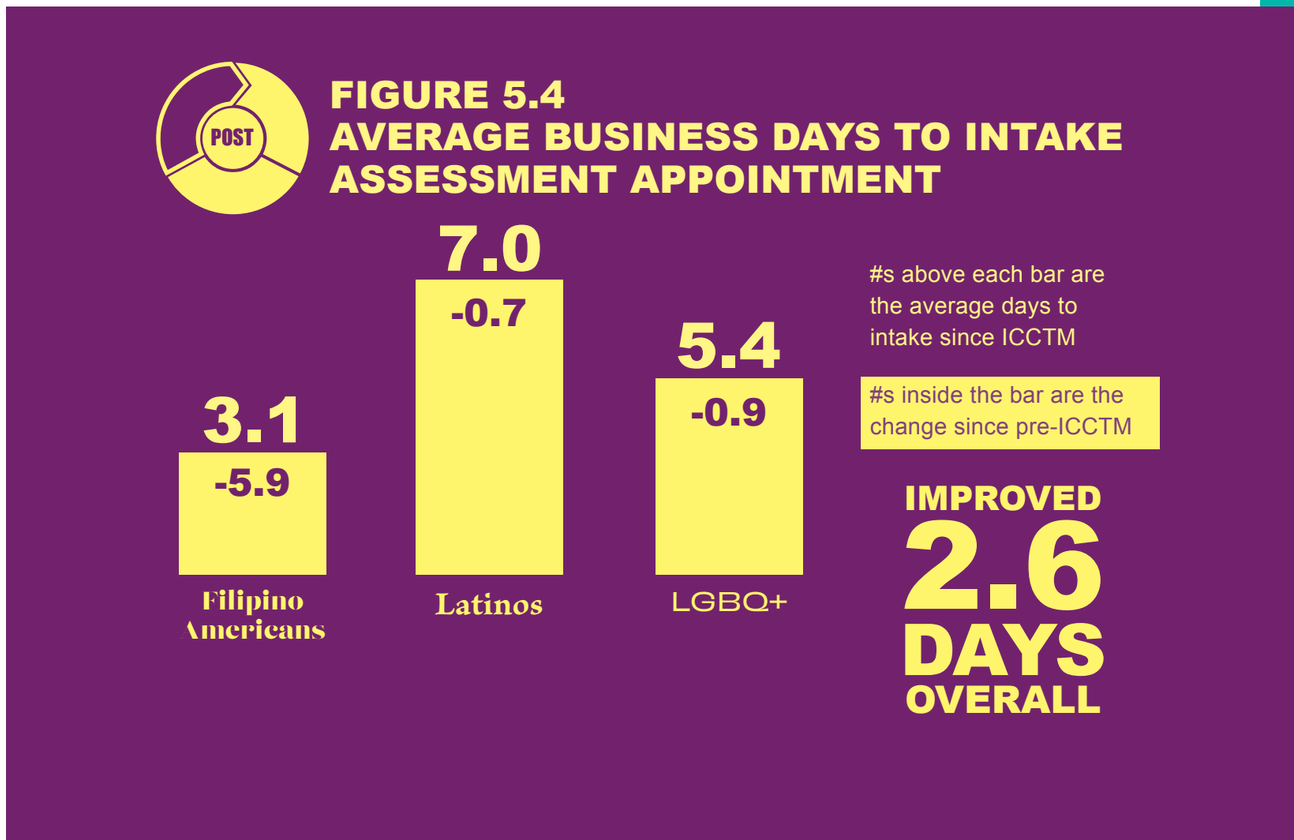
Among Filipino American Access Line users, the mean number of business days to obtain an offered intake assessment was greater than White Access Line users in the period before the ICCTM, 9 days versus 7.7 days average.

The mean number of days to obtain an intake assessment appeared to decrease over time among Filipino American Access line users at a rate greater than White Access Line users. During the ICCTM period, Filipino American Access Line users received an intake appointment on average 4 days sooner than White Access line users since ICCTM began.

By time period, among White Access Line users, the mean number of business days to obtain an offered intake assessment decreased over time in the pre-ICCTM and ICCTM periods but increased in the COVID-19 period. This pattern was seen among Latino Access Line users. Among Filipino American Access Line users, the mean number of business days to obtain an intake assessment offer increased in the COVID-19 period as well.

The mean number of business days to obtain an offered intake assessment improved among non-LGBQ+ Access Line users only. Among LGBQ+ Access Line users, the mean number of business days to obtain an intake assessment offer decreased only slightly, from 6.2 days in the pre-ICCTM period to 5.4 days in the ICCTM period.

Among non-LGBQ+ Access Line users, the mean number of business days to obtain an offered intake assessment decreased during the pre-ICCTM and ICCTM periods, but increased during the COVID-19 period. In contrast, among LGBQ+ Access Line users,



the mean number of business days to obtain an offered intake assessment did not decrease over time during the pre-ICCTM period, but did decrease over time during the ICCTM period. These findings suggest that the ICCTM Project may have contributed to the decreasing number of days to obtain an intake assessment offer among LGBQ+ Access Line users during the ICCTM period.

The mean number of business days to obtain an offered intake assessment improved among cisgender and non-cisgender Access Line users. Among cisgender Access Line users, the mean number of business days to obtain an intake assessment was 7.2 business days in the pre-ICCTM period and 4.7 business days in the ICCTM period. Meanwhile, among non-cisgender Access Line users, the mean number of business days to obtain an intake assessment offer was 7.1 business days in the pre-ICCTM period and 6.4 business days in the ICCTM period.

By time period, among cisgender Access Line users, the mean number of business days to obtain an offered intake assessment decreased during the pre-ICCTM and ICCTM periods, but increased during the COVID-19 period.

In contrast, among non-cisgender Access Line users, there were no significant changes over time during the pre-ICCTM, ICCTM, or COVID-19 time periods. This suggests that the ICCTM Project or other measures taken by SCBH may have protected non-cisgender Access Line users from the increase in number of business days to obtain an offered intake assessment seen in cisgender Access Line users.

In addition to not observing any significant trends in the mean number of business days to obtain an offered intake assessment among non-cisgender access line users, there also were no significant differences in the mean number of business days to obtain an offered intake assessment between gender identity groups.

Research Question 3

What proportion of callers were offered an intake assessment date that met the quality benchmark of being within 10 business days or less of the Access Line call for the three communities of focus?

The timeliness quality benchmark is an appointment offer within 10 business days. Overall, 57 percent of callers received timely appointment offers in the pre-ICCTM years compared to 76 percent in the period since the ICCTM. For all three communities of focus, the odds of obtaining an intake assessment appointment within 10 business days improved as shown in **Figure 5.5.**

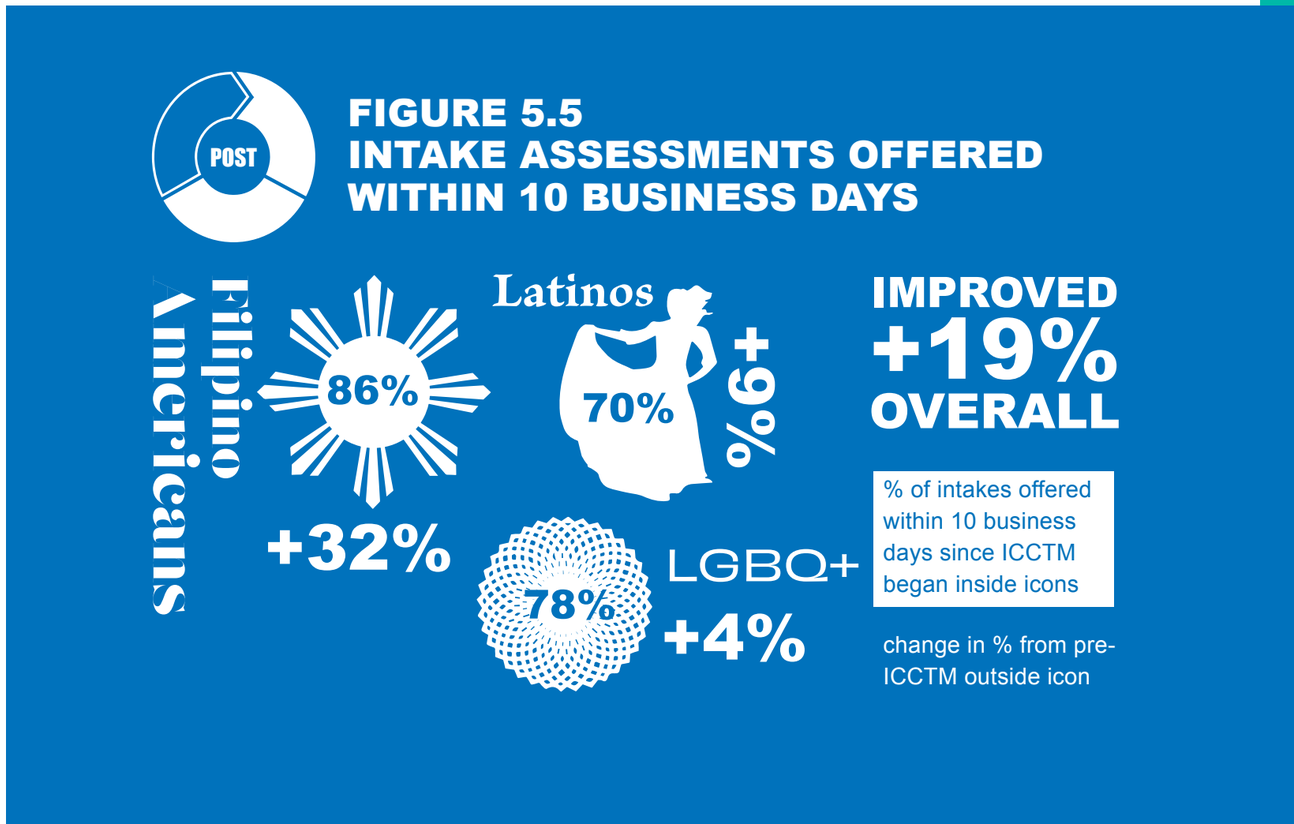
The improvement in odds of obtaining an offered intake assessment within 10 business days appeared to be greatest among Filipino American Access Line users with a 32 percent increase (from 54 to 86 percent) since ICCTM.

Among Latino callers, for example, the percent of callers who were offered an intake within 10 business days improved 9 percent since ICCTM began such that 70 percent of Latino callers received an intake within the benchmark time period.

For LGBQ+ Access Line callers, there was also an improvement, yet smaller than the improvement for the other two communities of focus. Since ICCTM began, the chance of obtaining an intake within 10 business days increased 4 percent for LGBQ+ callers to 78 percent.

When looking by time period, among White Access Line users, the odds of obtaining an offered intake assessment appointment after more than 10 business days decreased during the pre-ICCTM and ICCTM periods, but increased in the COVID-19 period.

Among Latino Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days improved over time during the pre-ICCTM and during the ICCTM periods.



During the COVID-19 period when timeliness may have been especially challenging, the proportion of Latino callers receiving appointment offers after more than 10 business days did not change.

It is possible that ICCTM Project or other measures put in place by SCBH buffered Latino Access Line users from obtaining an offered intake assessment after more than 10 business days in the COVID-19 period when compared to White Access Line users.

Among Filipino American Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days was unchanged over time in the pre-ICCTM period, but decreased in the ICCTM period, and remained unchanged in the COVID-19 period.

This suggests that the ICCTM Project or other measures taken by SCBH may have contributed to the decrease in odds of obtaining an offered intake assessment beyond the 10 business day quality benchmark among Filipino American Access Line users.

Despite the overall trend toward a higher percentage of callers being offered timely appointments over time, disparities may exist in a given fiscal year. Comparing Latino callers to White callers, the odds of obtaining an offered intake assessment after more than 10 business days were significantly greater during multiple fiscal years.

In FY 17-18, for example, the odds of obtaining an offered intake assessment after more than 10 business days was 1.50 times greater among Latino Access Line users compared to White Access Line users.

A potential explanation for these disparities may be due to how the likelihood of obtaining an offered intake assessment after more than 10 business days had decreased among White Access Line users at a greater rate compared to Latino Access Line users. In contrast, the odds of obtaining an offered intake assessment after more than 10 business days generally did not differ between Filipino American Access Line users versus White Access Line users.

One exception was in FY 16-17, when the odds of obtaining an offered intake assessment after more than 10 business days was 2 times greater among Filipino American Access Line users compared to White Access Line users. By FY 18-19, however, the odds of obtaining an offered intake assessment after more than 10 business days was 90 percent lower compared to White Access Line users.

By time period, among non-LGBQ+ Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days decreased (improved) over time in the pre-ICCTM and ICCTM periods, and significantly increased during the COVID-19 period.

In contrast, among LGBQ+ Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days did not change over time during the COVID-19 period. This suggests that the ICCTM Project or other measures taken by SCBH may have contributed to maintaining timely appointment offers among LGBQ+ Access Line users during the COVID-19 period.

The timeliness quality benchmark is an intake assessment offered within 10 business days. Among cisgender Access Line users, obtaining an offered intake assessment after more than 10 business days decreased (improved) over time, while this trend did not occur among non-cisgender Access Line users.

Among cisgender Access Line users, 65 percent received timely appointment offers in the pre-ICCTM period compared to 79 percent in the ICCTM period. Meanwhile, among non-cisgender access line users, 88 percent received timely appointment offers in the pre-ICCTM period compared to 75 percent in the ICCTM period.

By time period, among cisgender Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days decreased (improved) over time in the pre-ICCTM and ICCTM periods, and significantly increased during the COVID-19 period.

In contrast, among non-cisgender Access Line users, the odds of obtaining an offered intake assessment after more than 10 business days did not change during the COVID-19 period. This suggests that the ICCTM Project or other measures taken by SCBH may have contributed to maintaining timely appointment offers among non-cisgender Access Line users.

Research Question 4

Did the average duration between contacting the Access Line to starting an assessment appointment decrease (improve) in the period following the ICCTM Project and overall for the three communities of focus?

Overall, the amount of time between calling the Access Line and starting an intake assessment appointment has remained stable over time from an average of 12.9 calendar days in the 3-year period before the ICCTM Project (FY14-15 to FY16-17) to 13.2 calendar days in the 3-year ICCTM Project period

(FY17-18 to FY19-20) as shown in **Figure 5.6.**

Overall, 61 percent of callers had a timely assessment appointment in the pre-ICCTM years compared to 60 percent in the period since the ICCTM Project.

For Filipino American and Latino Access Line users, the mean number of calendar days between calling and completing an intake assessment did not significantly change over time, changing from 63 to 65 percent for Latinos and from 72 to 67 percent for Filipino Americans.

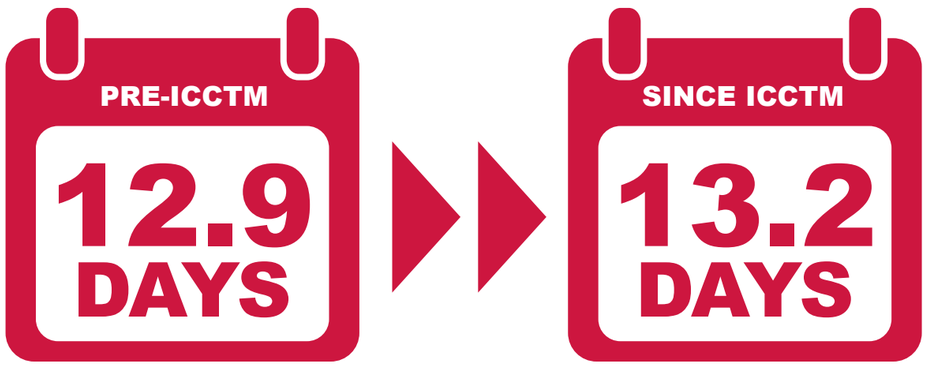
In some fiscal years, the mean number of calendar days to have an assessment appointment were significantly greater among Latino Access Line users compared to White Access Line users, namely in FY 14-15, FY 17-18, and FY 18-19.

In FY 18-19, for example, the mean number of calendar days to have an assessment appointment among Latino Access Line users were 3 days greater compared to White Access Line users.

In contrast, there were no significant differences in the mean number of days to have an assessment appointment when comparing Filipino American Access Line users to White Access Line users in all recorded fiscal years.

The findings related to the mean differences in number of days to start the assessment for the Latino callers as compared to White callers may in part be related to the need to secure a Spanish-speaking clinician or the availability of interpreter services for the assessment appointment/s.

FIGURE 5.6
DAYS TO ASSESSMENT APPOINTMENT



Alternatively, the finding related to there not being a difference in the mean number of days to start the assessment for the Filipino American callers compared to White callers is likely due to the fact that the demand for interpreter services among Filipino American community members is impacted by consumers not needing or wanting to use interpreter services.

The preference towards the English language is in part due to a cultural belief that speaking English is a sign of status, which is deeply entrenched in the Filipino American community and is further impacted by stigma related to having a mental health condition.

The mean number of calendar days to start an intake assessment was stable over time. Among non-LGBQ+ Access Line users, the mean number of calendar days to have an assessment appointment was 13 days in the pre-ICCTM period and 13 days in the ICCTM period.

However, among LGBQ+ Access Line users, the mean number of calendar days to have an assessment appointment increased from 10 days in the pre-ICCTM period and 14 days in the ICCTM period. These differences are likely to be due to the small number Access Line callers identifying as LGBQ+ especially in the pre-ICCTM period.

By time period, the mean number of calendar days to start an assessment appointment did not change over time among either LGBQ+ or non-LGBQ+ Access Line users during the pre-ICCTM, ICCTM, or COVID-19 periods. Furthermore, there were no significant differences in the mean number of calendar days to an assessment appointment when comparing these groups in any of the fiscal years observed.

The mean number of calendar days to start an intake assessment appointment did not change across fiscal years among cisgender access line users, but increased each fiscal year among non-cisgender access line users. Among cisgender Access Line users, the mean number of calendar days to have an assessment appointment was just under 13 days in the pre-ICCTM period and just over 13 days in the ICCTM period.

Among non-cisgender Access Line users, the mean number of calendar days to have an assessment appointment was 10 days in the pre-ICCTM period and 14 days in the ICCTM period. These differences are likely due to be due to the small number of Access Line users identifying as non-cisgender, especially in the pre-ICCTM period.

By time period, the mean number

of calendar days to complete an assessment appointment did not change over time among non-cisgender Access Line users during the pre-ICCTM, ICCTM, or COVID-19 periods. Also, there were no significant differences in the average number of calendar days to starting an assessment appointment when comparing these groups in any fiscal year.

CONCLUSION

Overall, the number of SCBH Access Line users increased since the ICCTM Project, while the proportion who identified as Filipino American, Latino, and LGBQ+ also increased, as shown in **Figure 5.7**.

Although the number of non-cisgender access line users increased, the proportion of Access Line users identifying as non-cisgender has not significantly changed possibly because SCBH only began to collect a broader range of sexual orientation and gender identity data from Access Line callers after the 2015 to 2016 fiscal year.

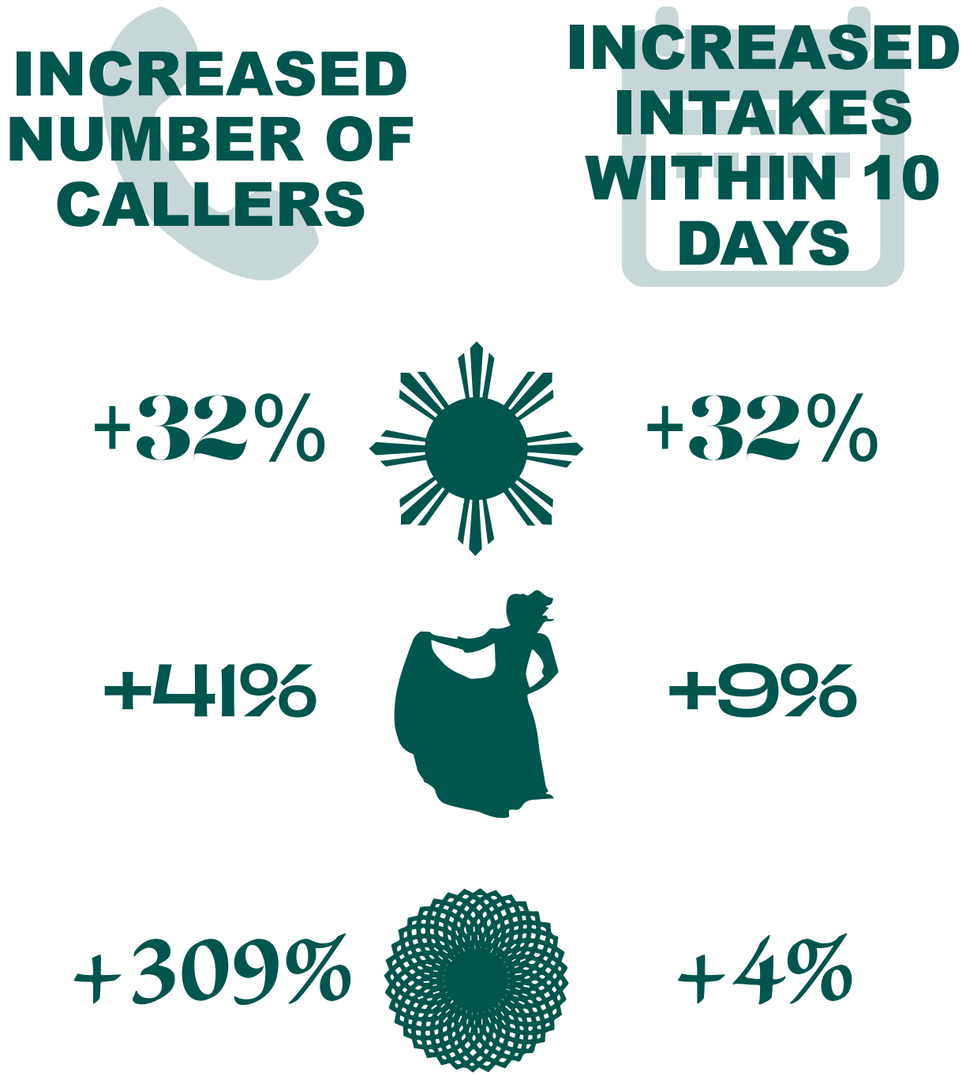
The majority of Filipino American, Latino, as well as LGBQ+ and non-cisgender Access Line users were offered an intake assessment within 10 business days, suggesting that Access Line services met quality benchmarks for timeliness.

Among Filipino American and LGBQ+ Access Line users, the odds of being offered an intake assessment that did not meet the 10 business days benchmark improved in the ICCTM period as shown in **Figure 5.7** suggesting that the ICCTM Project may have contributed to improvements in intake timeliness for these groups.

There were some challenges in timeliness of appointments during the COVID-19 period. White, non-LGBQ+, and cisgender Access Line users appeared to experience service deficits for intake assessment offers.

In contrast, this was not the case for Filipino American, Latino, as well as LGBQ+ and non-cisgender Access Line users. These results suggest that the ICCTM Project may have helped to buffer these priority populations from health service deficits that affected other groups.

FIGURE 5.7
IMPROVEMENTS IN SYSTEMS OF ACCESS FOR THREE COMMUNITIES OF FOCUS



5b

HEALTH OUTCOMES: UTILIZATION OF OUTPATIENT AND CRISIS SERVICES

The **Health Outcomes Summary Chapter Part 2** evaluates the potential contribution of the ICCTM Project on the utilization of outpatient and crisis services by examining data from the SCBH's Avatar electronic health record (EHR) system. The three communities of focus of the ICCTM Project include Filipino American, Latino, and LGBQ+ community members.

SCBH implements and oversees the operations of both the Solano Mental Health Plan (MHP) and the Solano Drug Medi-Cal Program. The Solano MHP is a healthcare system provides specialty mental health services for individuals with significant mental health conditions and who have Solano County Medi-Cal or are uninsured.

Meanwhile, the Solano Drug Medi-Cal Program is managed by the Partnership Health Plan of California and includes substance use treatment services provided through Beacon Health Services for individuals with Solano County Medi-Cal.

A key goal of the ICCTM Project was to increase the utilization of the behavioral health services and decrease the use of crises interventions, shifting from acute mental health care to preventative care.

For the purposes of this report the data is only reflective of MHP services as shown in **Figure 5.9**. SCBH MHP services include individual therapy and rehabilitation, family therapy or collateral groups for family members, group therapy and rehabilitation, collateral support

Figure 5.9
SCBH Services

(e.g., education and support for family members, caretakers, and other support individuals), crisis intervention services, case management (e.g., referral and linkage to community resources), and psychiatric evaluation and medication management (SCBH, 2021a).

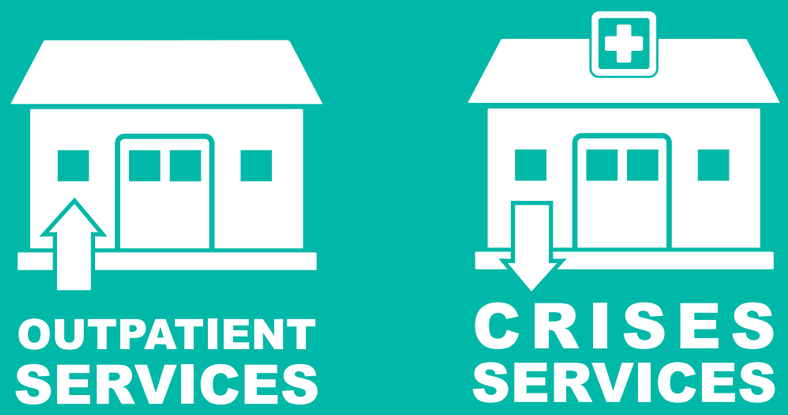
While most SCBH consumers enter the system of care through outpatient care, many also experience a mental health crisis before connecting to care.

Access to effective outpatient care should mitigate the use of crisis services, which would be reflected in a decrease in point-of-entry through crisis services among SCBH consumers as shown in **Figure 5.10.**

While the ICCTM Project aimed to increase access to services through outpatient care, it should be noted that entry to the system of care through a crisis program can also be viewed as an improvement for the communities of focus who often do not seek out services even in a crisis.

This evaluation focused on assessing outpatient services utilization, crises service utilization, and point of entry into the SCBH System of care via crises services.

FIGURE 5.10
INTENDED IMPROVEMENTS BY SERVICE TYPE



METHODS

The data used for the evaluation was obtained from Solano County's Avatar EHR system and includes all records for when consumers have utilized community-based outpatient services and/or crisis services between July 1, 2015 and September 30, 2020 (i.e., Fiscal Year 2015-2016 through September 30, 2020).

Consumers served through long term subacute facilities or institutions of mental disease (IMDs) and augmented board and cares (ABCs) were excluded from the data set provided. Each record provides the date a consumer utilized a service, the description of the type of service used, as well as an admission date associated with the consumer's most recent episode (consumers may have multiple admissions over time). These records also include demographic data for the consumer (e.g., race/ethnicity, sexual orientation, and gender identity).

FIVE MEASURES

1. Number of Outpatient Service Users: Number of outpatient service users (unduplicated consumers) from July 1, 2015 through September 30, 2020, overall and among the priority populations of the ICCTM Project, which include Filipino American, Latino, and LGBTQ+ community members. For the purposes of evaluation we will look at LGBQ+ consumers compared to the non-LGBQ+ consumers; and non-cisgender versus cisgender consumers.
2. Number of Outpatient Services Used: Average number of services used among outpatient consumers within a given time period (e.g., fiscal year or quarter).
3. Number of Crisis Service Users: Number of crisis service users (unduplicated consumers) from July 1, 2015 through September 30, 2020, overall and among the communities of focus of the ICCTM Project, which include Filipino American, Latino, and LGBQ+ community members. For the purposes of evaluation we will look at LGBQ+ consumers compared to the non-LGBQ+ consumers; and non-cisgender versus cisgender consumers.
4. Number of Admissions to a Crisis Service Program: Number of admissions to a crisis service program among consumers within a given time period (e.g., fiscal year or quarter). The quality benchmark is three or fewer admissions to crisis service program within a fiscal year, or two or fewer admissions to a crisis service program within a quarter.

   A crisis program can be one of three types: (1) crisis stabilization unit (CSU), a 23-hour stabilization program; (2) crisis residential

treatment, a two-week program for adults only; and/or (3) Inpatient facility, for which the average stay is 10 days.

Therefore, an admission to a crisis service program does not necessarily equate to a unique crisis episode. For example, during an acute crisis episode, a consumer may have an admission to the CSU as well as an inpatient facility, which then counts as two admissions to a crisis program.

5. First Admission via Crisis Services: Among consumers who had their first admission within a given time period (e.g., fiscal year or quarter), the number of those whose admission was through a crisis service.

ANALYSIS

Trends in outpatient and crisis service utilization were examined by fiscal year and by quarter. When examining the potential influence of the ICCTM Project on outpatient and crisis service utilization over fiscal years among the priority groups, following time periods were defined:

- Pre-ICCTM: July 1, 2015 through June 30, 2017 (i.e., FY 15-16 and FY 16-17; 24 months)
- ICCTM Period: July 1, 2017 through June 30, 2020 (i.e., FY 17-18 through FY 19-20; 36 months)

When examining the potential influence of the ICCTM Project and COVID-19 on outpatient and crisis service utilization, quarterly comparisons were made between Pre-ICCTM, ICCTM, and COVID-19 periods. The ICCTM period was re-categorized as July 1, 2017 through December 1, 2019. And the COVID-19 period was defined as January 1, 2020 through September 20, 2020.

RESULTS

The results from the analyses of outpatient and crisis service users are presented below. Additional tables supporting the analysis, such as statistical tests and quarterly data, are available on the SCBH and UCD CRHD websites.

For the purposes of this report, when analyzing data related to race and ethnicity, White consumers were used as the reference/comparison group when assessing service utilization among Filipino American and Latino consumers.

Similarly, when analyzing data related to sexual orientation and service utilization, non-LGBQ+ consumers were used as the reference/comparison group. And when analyzing data related to current gender identity, cisgender consumers were used as the reference/comparison group.

Research Question 1

How many consumers used SCBH's outpatient services and did the number and proportion of consumers increase (improve) in the period following the ICCTM Project and overall, for the three communities of focus?

Overall, the number of unique outpatient service users remained stable, with an average of 4,948 consumers per year in the 2-year period before the ICCTM Project and 4,754 consumers per year in the 3 year period since the ICCTM Project as shown in Figure 5.11. These do not include consumers in long-term acute facilities.

Among the three communities of focus however, the proportion of outpatient service users increased for all three communities of focus. The number and proportion of Latino outpatient service users increased from 17 percent to 19 percent in the ICCTM period, the percent remained stable at 4 percent for Filipino Americans, and doubled from 4 percent to 8 percent for LGBQ+ consumers as shown in Figure 5.12.

For Filipino American consumers, the number of outpatient service users remained stable at approximately 180 people per year and their representation (proportion) also remained stable at approximately 4 percent.

Though detailed data are not presented here, increases for

FIGURE 5.11
AVERAGE OUTPATIENT SERVICE USERS BEFORE AND SINCE ICCTM

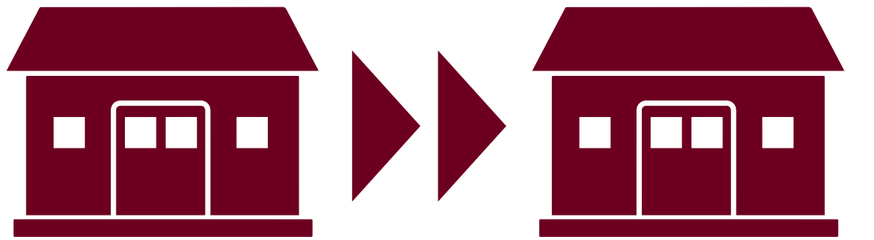
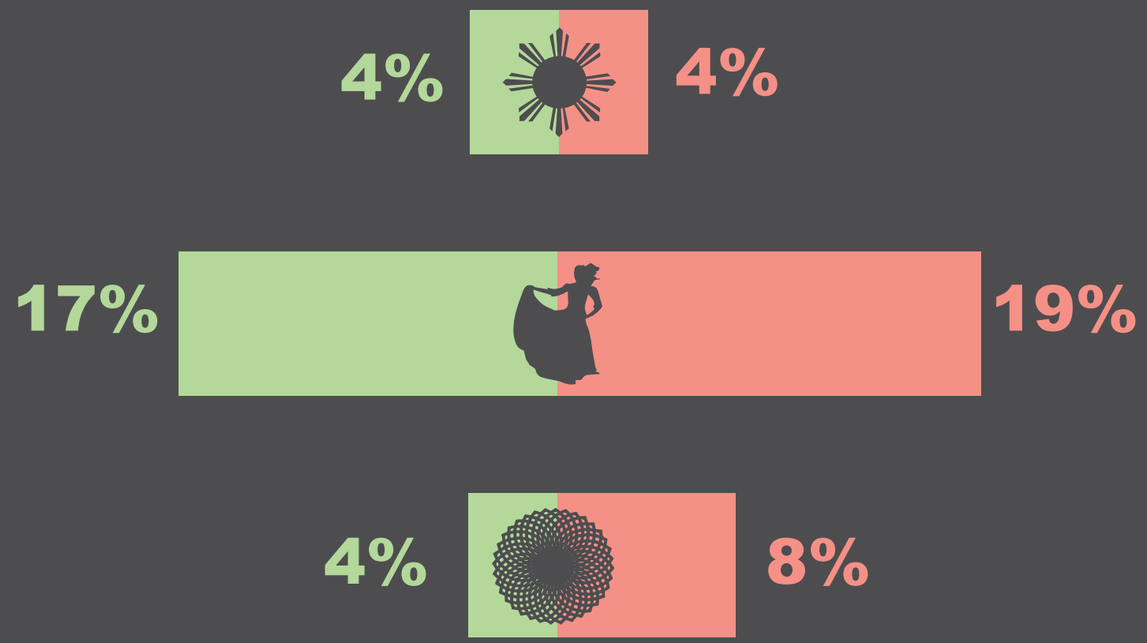


FIGURE 5.12
PERCENT OF OUTPATIENT SERVICES BEFORE AND SINCE ICCTM



all race/ethnicity groups except American Indian or Alaskan Native consumers were higher when compared to the White race/ethnicity group.

These trends appeared to vary by time period. Outpatient service users were significantly more likely to identify as Latino versus White across quarters during the ICCTM period, but not during the pre-ICCTM or COVID-19 periods. This suggests that the ICCTM Project or other measures put in place by SCBH improved the proportion of Latino outpatient service users during the ICCTM period specifically.

The number and proportion of LGBQ+ outpatient service users improved annually as shown in **Figure 5.12.** About 4 percent of outpatient service users identified as LGBQ+ during the pre-ICCTM period compared to 8 percent during the ICCTM period. This suggests that the utilization of outpatient services improved among LGBQ+ consumers.

The number and proportion of non-cisgender (transgender, genderqueer, two-spirit, questioning, or any other gender identity) outpatient service users also improved annually.

Specifically, 0.6 percent of outpatient service users identified as non-cisgender during the pre-ICCTM period compared to 1 percent during the ICCTM period. This suggests that the utilization of outpatient services remained stable among non-cisgender consumers.

Research Question 2

Did the average number of services used among outpatient service consumers increase (improve) in the period following the ICCTM Project and overall for the three communities of focus?

Overall, the average number of services used among outpatient consumers improved from an average of 20 in the two-year period before the ICCTM Project to 22 in the three-year ICCTM period**.**

Among all consumers, the average number of outpatient services used per year increased 1.6 percent as shown in **Figure 5.13.** Among Latino consumers, the average number of outpatient services used increased by 0.8 percent, but decreased 1.6 percent for Filipino Americans and 0.4 percent for LGBQ+ consumers.

Data points recorded for FY 18-19 are reported below given that FY 19-20 includes the COVID-19 pandemic period and may not be representative of the delivery of services in other years.

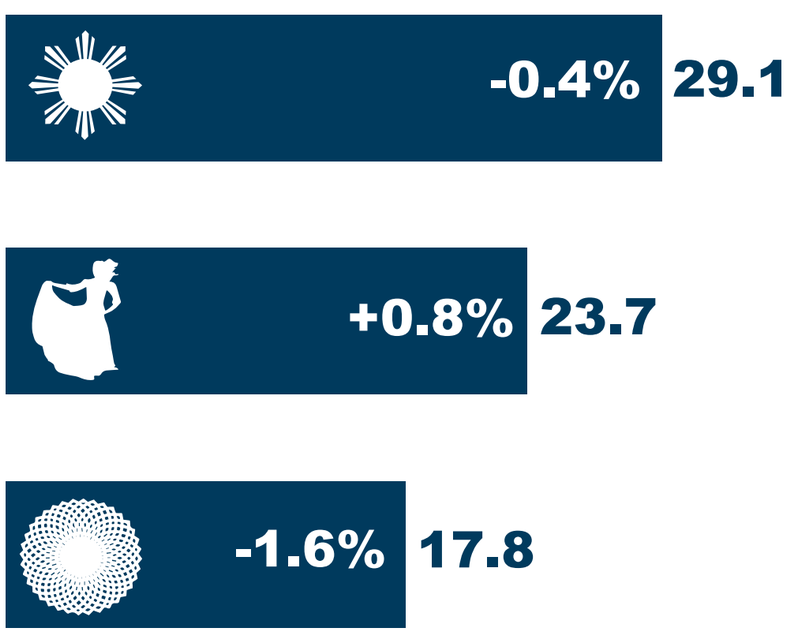
The average number of outpatient services used by other consumers

appeared to vary by time period. Among White consumers, the average number of outpatient services used increased during the pre-ICCTM period and decreased during the ICCTM period.

In contrast, among Latino consumers, the average number of outpatient services used during the ICCTM period did not decrease as seen among White consumers.

It is possible that the ICCTM Project or other measures put in place by SCBH buffered Latino outpatient service users from the factors resulting in the decreased use of outpatient services seen among White service users.

FIGURE 5.13
AVERAGE NUMBER OF OUTPATIENT SERVICES USED PER CONSUMER PER YEAR



It is also worth noting that, over multiple fiscal years, the average number of outpatient services used was greater among Latino consumers compared to White consumers.

Therefore, as the number of outpatient services used continued to increase (improve) among Latino consumers, their utilization of these services has been found to be greater compared to White consumers during certain periods.

Among LGBQ+ consumers, the average number of outpatient services used appeared to remain stable at 30 during the pre-ICCTM period and 29 during the ICCTM period. Indeed, the overall trend across time was not found to be statistically significant.

Although the average number of outpatient services used among LGBQ+ consumers was not found to change across time, the average number of outpatient services used among LGBQ+ consumers was significantly greater than non-LGBQ+ consumers over multiple fiscal years.

Among non-cisgender consumers, the average number of outpatient services used appeared to remain stable at 36 during the pre-ICCTM period and 37 during the ICCTM period. Indeed, the overall trend across time was not found to be statistically significant.

Although the average number of outpatient services used among non-cisgender consumers was not found to change across time, the average number of outpatient services used among non-cisgender consumers was significantly greater than cisgender consumers over multiple fiscal years.

Research Question 3

How many consumers used SCBH's crisis services and did the number and proportion of consumers decrease (improve) in the period following the ICCTM Project and overall for the three communities of focus?

Overall, the number of unique crisis service users has decreased (improved), with an average of 1,616 consumers per year in the 2 year period before the ICCTM Project and 1,246 consumers per year in the 3 year period since the ICCTM Project.

Although the number of Latino crisis service users decreased annually, their proportion increased slightly. Specifically, 14 percent of crisis service users identified as Latino during the pre-ICCTM period compared to 15 percent in the ICCTM period as shown in **Figure 5.14.**

Meanwhile, the proportion of crisis service users that identified as

Filipino American appeared to remain stable at about 4 percent. According to the trend model, the likelihood that crisis service users identified as Latino increased overall, whereas the likelihood of identifying as Filipino American did not significantly increase. Furthermore, these trends did not appear to vary by pre-ICCTM, ICCTM, or COVID-19 time periods.

The number and proportion of LGBQ+ crisis service users increased (or did not improve) annually. Specifically, 5 percent of crisis service users identified as LGBQ+ during the pre-ICCTM period compared to 10 percent during the ICCTM period as shown in **Figure 5.14.** This suggests that the utilization of crisis services increased among LGBQ+ consumers. This trend did not vary by time period.

It is possible that crisis service use among LGBQ+ consumers during the pre-ICCTM period may have been underestimated, leading to the appearance that crisis service utilization among LGBQ+ consumers has increased.

Nevertheless, given that the proportion of LGBQ+ outpatient and crisis service users increased, these findings taken together suggest that the utilization of all behavioral health services in Solano County has increased over time for these groups.

One consideration regarding the growing number of LGBQ+ crisis service users is how this trend occurred simultaneously with the improved data collection techniques at SCBH to collect sexual orientation identification information.

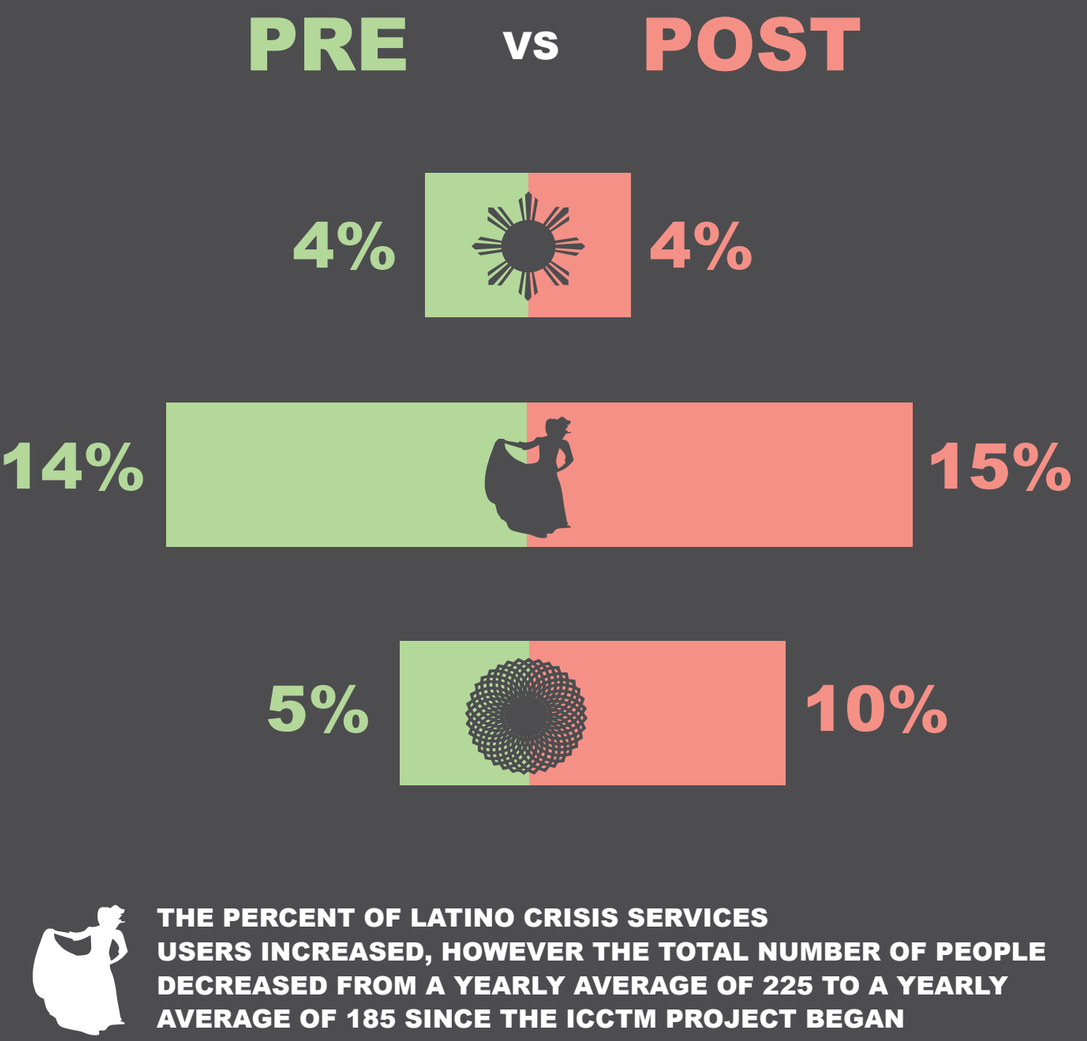
The number and proportion of non-cisgender crisis service users did not significantly change annually. Specifically, 0.6 percent of crisis service users identified as non-cisgender during the pre-ICCTM period compared to 0.9 percent during the ICCTM period. This suggests that the utilization of crisis services remained stable among non-cisgender consumers. Furthermore, this trend did not vary by time period.

Research Question 4

Did the proportion of crisis service users who had more than 3 admissions to a crisis program per fiscal year (or more than 2 admissions per quarter) decrease (improve) in the period following the ICCTM Project and overall for the three communities of focus?

The quality benchmark for the number of admissions among crisis service users is either three or less per fiscal year, or two or less per quarter. Among Latino crisis service users, the proportion of those with more than three admissions to a crisis program increased from 8

FIGURE 5.14
PERCENT OF CRISES SERVICES CONSUMERS BY GROUP BEFORE AND AFTER ICCTM



THE PERCENT OF LATINO CRISIS SERVICES USERS INCREASED, HOWEVER THE TOTAL NUMBER OF PEOPLE DECREASED FROM A YEARLY AVERAGE OF 225 TO A YEARLY AVERAGE OF 185 SINCE THE ICCTM PROJECT BEGAN

percent in the pre-ICCTM period to 14 percent in the ICCTM period.

Similarly, among Filipino American crisis service users, the proportion of those with more than three admissions to a crisis program increased from 8 percent in the pre-ICCTM period to 13 percent in the ICCTM period.

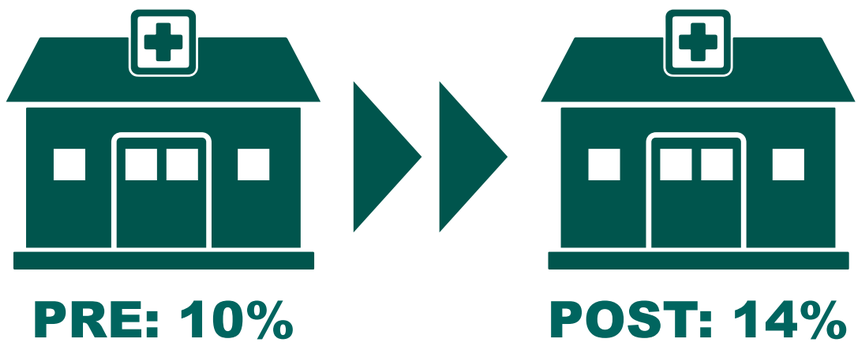
Although the proportion of crisis service users who had more than three admissions to a crisis program per fiscal year increased among the ICCTM Project communities of focus from 10 percent to 14 percent as shown in **Figure 5.15**, there are some noteworthy considerations when the data were examined by quarters.

A similar trend was observed for Filipino American, Latino, as well as White crisis service users, where their likelihood of having more than two admissions increased overall each quarter.

The increasing trend among White crisis service users varied by time period. The increase was significant during the ICCTM period but not during any other periods. In contrast, among Latino as well as Filipino American crisis service users, there was no significant increase in the likelihood of having more than two admissions to a crisis program across quarters during the ICCTM period.

Together, these findings suggest that the ICCTM Project may have protected Latino and Filipino

FIGURE 5.15
FREQUENT ADMISSION TO CRISES SERVICES PROGRAMS



American crisis service users from the increased likelihood of having more than two admissions to a crisis program during the ICCTM period as seen among White consumers.

Furthermore, across all fiscal years studied, the likelihood of having more than three admissions to a crisis service program did not significantly differ between Latino consumers and White consumers, as well as between Filipino American consumers and White consumers.

Among LGBQ+ crisis service users, the proportion of those with more than three admissions to a crisis service program remained stable, increasing from 14 percent to 16 percent in the ICCTM period.

When examining this trend across quarters, the likelihood of having more than two admissions to a crisis service program increased each quarter among non-LGBQ+ consumers. The trend also varied by time window, such that the likelihood of having more than two admissions to a crisis service program decreased each quarter during the pre-ICCTM period and increased during the ICCTM period.

Among LGBQ+ consumers, the likelihood of having more than two admissions to a crisis service program remained stable overall, including during the ICCTM period, which contrasts with the increase seen among non-LGBQ+ consumers. It is possible that the ICCTM Project may have protected LGBQ+ consumers from the increased likelihood of having more than two admissions to a crisis service program.

Even though likelihood of having more than three admissions to a crisis service program did not significantly change over time among LGBQ+ consumers, it is notable that the likelihood of having more than three admissions to a crisis service program did not significantly differ between LGBQ+ and non-LGBQ+ consumers in any fiscal year recorded.

Among non-cisgender crisis service users, the proportion of those with more than three admissions to a crisis service program was 15 percent in the pre-ICCTM period and 9 percent in the ICCTM period. This change was not statistically significant, given the small number of crisis service users identifying as non-cisgender.

When examining this trend across quarters, the likelihood of having more than two admissions to a crisis service program increased each quarter among cisgender consumers. The trend also varied by time window, such that the likelihood of having more than two crisis service admissions decreased each quarter during the pre-ICCTM period and increased during the ICCTM period.

In contrast, among non-cisgender consumers, the likelihood of having more than two admissions to a crisis service program remained stable overall, including during the ICCTM period, which contrasts with the increase seen among cisgender consumers.

It is possible that the ICCTM Project may have protected non-cisgender consumers from the increased likelihood of having more than two admissions to a crisis service program.

Even though likelihood of having more than three admissions to a crisis service program did not significantly change over time among non-cisgender consumers, it is notable that the likelihood of having more than three admissions to a crisis service program did not significantly differ between non-cisgender and cisgender consumers in any fiscal year.

Research Question 5

Did the proportion of behavioral health service users who had their first admission through crises services decrease (improve) in the period following the ICCTM Project and overall, for the three communities of focus?

The percent of people with a first admission to behavioral health services through crises services decreased 8 percent for the communities of focus. Among the three communities of focus, consumers who were admitted to SCBH system of care decreased from 36 percent to 28 percent, an 8 percent improvement since ICCTM as shown in **Figure 5.16.**

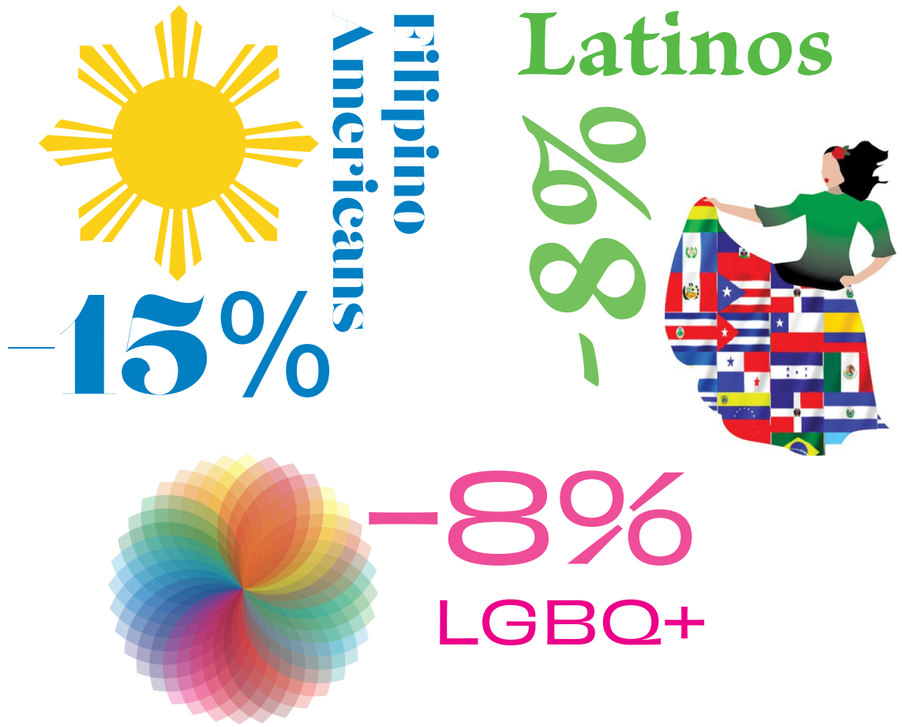
The proportion of Latino consumers whose first admission was through crisis services decreased (improved) to 24 percent during the ICCTM period from 33.

Meanwhile, among Filipino American consumers who were admitted to SCBH services in the pre-ICCTM period, 50 percent entered through crisis services. The proportion of Filipino American consumers whose first admission was through crisis services then improved to 36 percent during the ICCTM period.

When examining the quarterly data, the overall decrease in entering SCBH system of care via crisis services was statistically significant for both Latino and Filipino American community members.

These trends varied by time period for Filipino American consumers. Among Filipino American consumers who had their first admission during the pre-ICCTM period, the likelihood of entering through crisis services did not significantly change across quarters.

FIGURE 5.16
DECREASE IN FIRST ADMISSIONS VIA CRISES SERVICES



During the ICCTM period, however, the likelihood of entering through crisis services improved across quarters. This suggests that the ICCTM Project may have contributed to the reduced likelihood of first admission via crisis services among Filipino American consumers during the ICCTM period.

In nearly all fiscal years reported, Latino consumers had a lower likelihood of having their first admission via crisis services compared to White consumers.

Meanwhile, there were no significant differences in the likelihood of first admission via crisis services comparing Filipino American consumers to White consumers. Taken together, these findings suggest improvements in point of entry for both Latino and Filipino American behavioral health consumers as well as closing disparities on this metric.

Among LGBQ+ consumers who were admitted to SCBH system of care in the pre-ICCTM period, 43 percent entered through crisis services and decreased to 35 percent during the ICCTM period.

When examining the quarterly data, this trend did not vary by time period. Meanwhile, in all fiscal years reported, LGBQ+ consumers either had a lower likelihood of having their first admission via crisis services compared to non-LGBQ+ consumers, or there was no significant difference between groups.

Among non-cisgender consumers who were admitted to SCBH system of care in the pre-ICCTM period, 50 percent entered through crisis services.

The proportion of non-cisgender consumers whose first admission was through crisis services decreased (improved) to 27 percent during the ICCTM period. When examining the quarterly data, this trend did not vary by time period.

Meanwhile, in all fiscal years reported, there was no significant difference between non-cisgender and cisgender consumers in their likelihood of having their first admission via crisis services

CONCLUSION

Among outpatient behavioral health service users in Solano County, the proportion identifying as Filipino American, Latino, and LGBQ+ increased over time. The proportion of outpatient service users who identified as non-cisgender also increased slightly.

The average number of services used per year per consumer also increased over time overall, though among the communities of focus only the Latino consumers followed this trend.

Crisis service use decreased overall between the pre-ICCTM and ICCTM period although the proportion of users who were Filipino American, Latino, and LGBQ+ consumers increased somewhat.

Notably, the proportion of consumers who entered the SCBH system through crisis service (rather than outpatient service) decreased (improved) during the ICCTM period overall and for each of the communities of focus.

This may be indicative of a shift from acute mental health care via crisis services to more preventative outpatient care, which was a key goal of the ICCTM Project and those complementary efforts implemented by SCBH.

The analysis of health outcomes suggests that the ICCTM Project may have contributed to improved access and timeliness of care as well as an overall increase in behavioral health service utilization among Filipino American, Latino, and LGBQ+ individuals residing in Solano County.

Among non-cisgender consumers, changes were not detected either due to small numbers of consumers in that category or because their utilization of behavioral health services has generally remained stable over time.

6 ECONOMIC EVALUATION

INTRODUCTION

This report presents findings from the economic evaluation of the SCBH ICCTM Project. This economic evaluation was conducted in accordance with the Quadruple Aim of the ICCTM Project centered on cost-effectiveness. The evaluation was divided into two parts:

1. Economic evaluation of the Providing Quality Care with CLAS (Cultural and Linguistic Appropriate Standards) Training, which is a component of the ICCTM Project
2. Economic evaluation of the ICCTM Project overall

The CLAS Training Economic Evaluation focused on increases (improvements) in participants' knowledge and confidence about CLAS and their cultural responsivity, especially toward engaging with the three communities of focus: Filipino American, Latino, and LGBTQ+.

The costs used in this evaluation considered the costs of developing and administrating the Providing Quality Care with CLAS Training Program in Solano County.

The Overall ICCTM Project Economic Evaluation assessed the costs for the multi-year project and its effect on decreasing point of entry into SCBH system of care. This involved monitoring shifts among consumers from having first admissions to the SCBH System of Care via Crisis Services to first admissions via Outpatient Services instead. This outcome was assessed using data from the SCBH Avatar electronic health record system. Costs used in this evaluation considered the overall cost of the ICCTM Project, which incorporates the cost of the CLAS Training component.

The Providing Quality Care with CLAS Training Program and the ICCTM Project overall served as an investment in Solano County to transform culture and community engagement in the delivery of mental health services. Future research could consider its economic value in the context of the program's impact across all its aims: improving consumer experiences, improving provider experiences, advancing population health, and utilizing approaches that are cost-effective.

The impact of the ICCTM Project for the communities of focus is broad and is still evolving. Future endeavors may include exploring less resource intensive ways to deliver CLAS Training and ICCTM overall with similar effectiveness.

METHODS

An economic evaluation studies the efficiency with which a program meets its goals. The type of

economic evaluation we conducted is called a cost-effectiveness analysis. It features analyses of cost and effectiveness data simultaneously.

Before reporting on cost-effectiveness in an economic evaluation, the effectiveness and costs of a program are first discussed. For example, for the CLAS Training Program Economic Evaluation, evaluators first separately assessed the CLAS Training's incremental effectiveness and costs.

The CLAS Training Program's cost-effectiveness using measures developed for the Providing Quality Care with CLAS Training Evaluation Report were used. For the Overall ICCTM Project, the project's overall effectiveness in terms of data on point-of-entry into the SCBH system of care among consumers was used and then costs were estimated separately before presenting the cost-effectiveness results.

Costs

For this economic evaluation, the costs were computed from the perspective of SCBH. This cost perspective includes County costs related to funding CRHD to prepare, and implement in the program.

For the CLAS Training, for example, costs included those related to trainers, coordinators, project managers, evaluators, and personnel expenses (SCBH staff costs including participants for the CLAS Training). Costs are typically computed as Price x Quantity. In some cases, an overall estimate of cost was used as was the case for the Overall ICCTM Project Economic Evaluation.

In other cases, assumptions were made about either Price or Quantity, which occurred in the Providing Quality Care with CLAS Training Economic Evaluation. For example, the CLAS training occurred in a building, and for the "base-case" analysis of how the program was actually implemented, the "Building Space" cost was set at $0. If this training were conducted elsewhere, however, meeting rooms may need to be rented.

Cost-Effectiveness

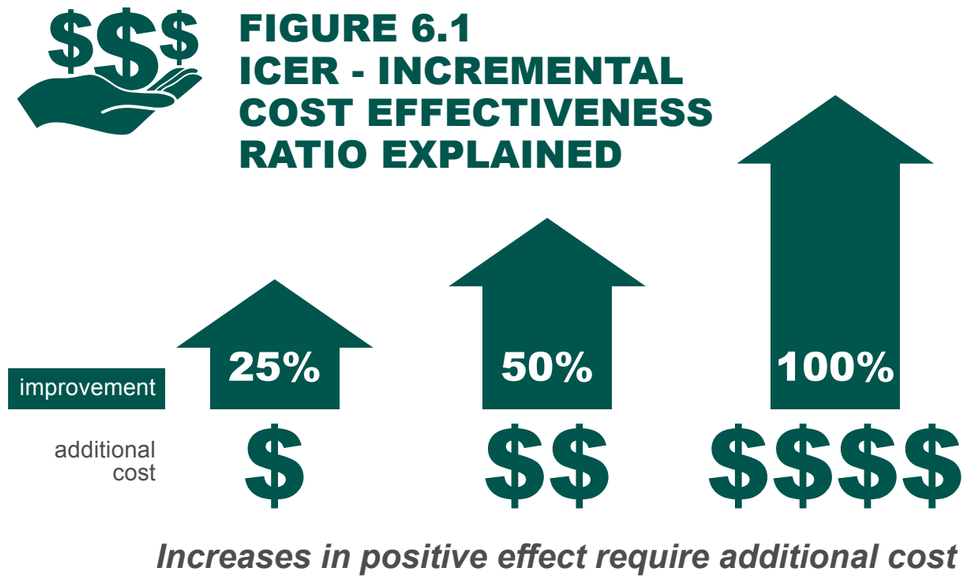
When describing a program's cost-effectiveness, evaluators calculated and assessed its incremental cost-effectiveness ratio (ICER).

The ICER is the conventional statistic in a cost-effectiveness analysis, and it conveys the extra cost for an additional unit of extra effect as shown in **Figure 6.1** For example, if the extra cost per person of the CLAS Training Program is $9,000 and the extra effect per person is an increase of 0.50 units in their Overall Cultural Responsivity, then the ICER equals $9,000 / 0.50 = $18,000 per additional unit improvement in the Overall Cultural Responsivity measure.

Given these components, each part of the economic evaluation (one part for the CLAS Training Program and one part for the ICCTM Project Overall) includes a section on effectiveness, cost, and cost-effectiveness.

PART 1: ECONOMIC EVALUATION OF THE PROVIDING QUALITY CARE WITH CLAS TRAINING

The total cost of providing the Providing Quality Care with CLAS Training Program was $464,883 for 51 people or $9,115 per participant.



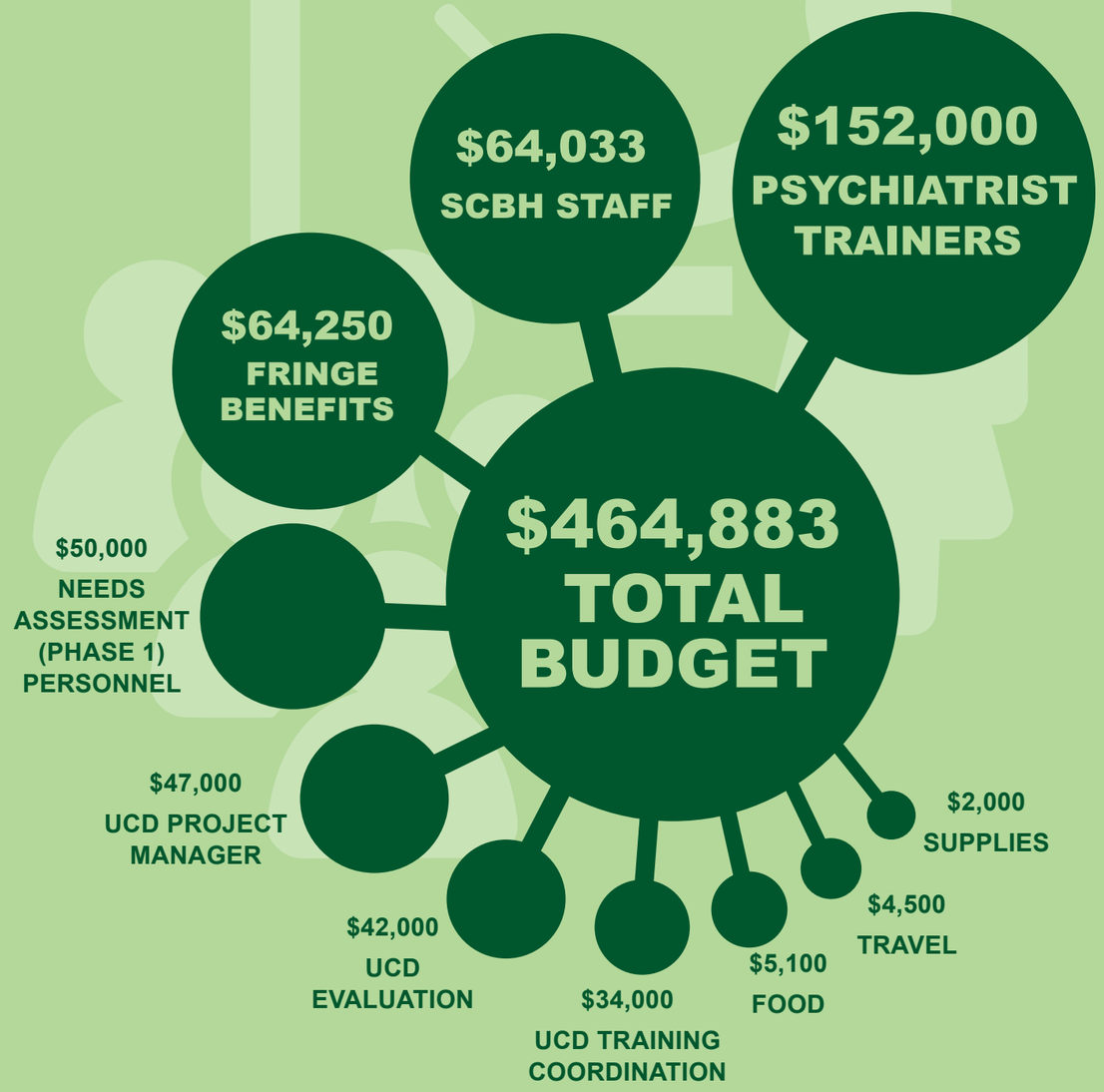
Note that participants demonstrated significant improvements in all key cultural responsivity outcomes.

Cost of Providing Quality Care with CLAS Training

The Providing Quality Care with CLAS Training Program was estimated to cost $464,883. This is composed of robust investments in personnel (for needs assessment, curriculum development, training, coordination, evaluation and project management) and also included SCBH participant time as shown in **Figure 6.2.**

The main cost categories included personnel for needs assessment, training, coordination, evaluation,

FIGURE 6.2
COSTS ASSOCIATED WITH CLAS TRAINING



project management and SCBH staff participation in the training. Other costs included miscellaneous items such as travel, food, supplies, and building space. The cost estimates include expenditures from Phase 1 of the ICCTM Project (Comprehensive Cultural Needs Assessment):

- Key informant interviews
- Focus groups
- Community forums
- Organizational surveys with stakeholders, cultural brokers, and community leaders representing the three communities of focus

These individuals shared their experiences with accessing and using mental health services in Solano County and findings were used to develop the Providing Quality Care with CLAS Training Program curriculum to be specially tailored to Solano County, which serves as one of the innovative aspects of the ICCTM Project.

During the ICCTM Project period, medically licensed psychiatrists with expertise on the delivery of culturally and linguistically appropriate services acted as the trainers for the Quality Care with CLAS Training Program. CLAS Trainings were organized by a team of master's and doctoral level (e.g., MPH or PhD) coordinators, evaluators, and project managers. Travel expenses were included for trainers and program staff to go to the training site to conduct the CLAS Training. The cost estimate also included costs for food as an incentive for participants to participate in the CLAS Training.

To compute the cost to SCBH for its staff to participate in the training, it was estimated that the time taken away from regular work for SCBH staff totaled $64,033. It is important to note, however, that there is no estimate included in this analysis for the time spent by individuals who worked outside of SCBH and participated in trainings.

Effectiveness of the Providing Quality Care with CLAS Training

The data for the effectiveness outcomes of the Providing Quality Care with CLAS Training Program came from participants' pre- and post-training self-assessment surveys that included items pertaining to participants' knowledge and confidence about CLAS, involvement in mental health service quality improvement, and involvement in addressing barriers to mental health services.

A positive change due to the training was calculated as the difference between Pre-Survey Score – Post-Survey Score, > 0 in the expected direction. Since the measures were scored on a five-point scale, evaluators noted that a 1-point improvement on a measure

represented a 20 percent improvement.

Evaluators looked at the effect of the training on participants' Knowledge and Confidence about CLAS and created a composite score that combined three sets of items included in Overall Cultural Responsivity:

1. Knowledge & Confidence about CLAS
2. Involvement in Quality Improvement
3. Involvement in Addressing Barriers

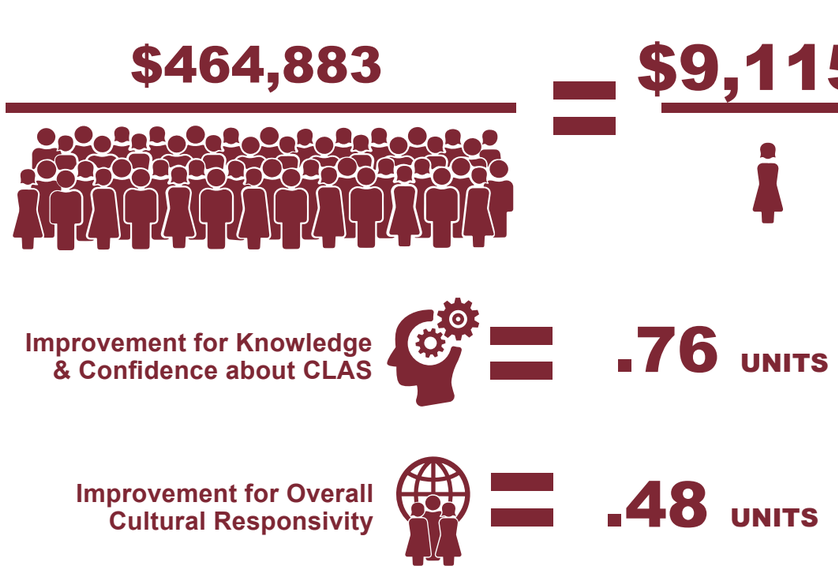
Cost-Effectiveness of the Providing Quality Care with CLAS Training

The expected cost and effect estimates of the CLAS Training are shown in **Figure 6.3.** The Providing Quality Care with CLAS Training Program was estimated to have a total cost of $464,883.

Dividing the total cost by the 51 people trained provides an estimate of the Expected or Average Cost per person trained.

FIGURE 6.3

COSTS AND OUTCOMES TO TRAIN 51 PEOPLE IN CLAS STANDARDS



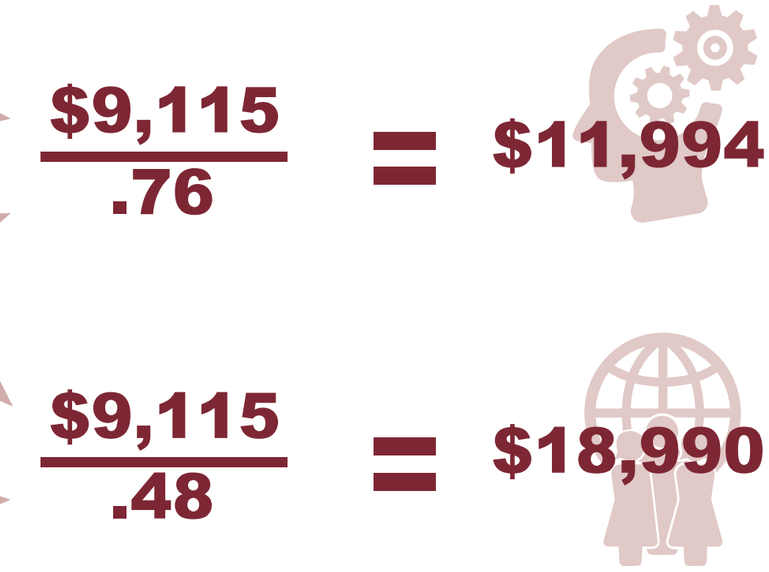
For the CLAS training, the extra cost was $9,115 per person. For the cost-effectiveness analysis, the pre- to post-training improvement for Knowledge and Confidence about CLAS was 0.76 units.

The composite measure of Overall Cultural Responsivity (i.e., the combined score for participants' knowledge and confidence about CLAS, involvement in quality improvement, and involvement in addressing barriers) captures a broader range of outcomes that were significantly improved among participants of the CLAS Training Program beyond just knowledge and confidence about CLAS. The pre-post training difference in Overall Cultural Responsivity was .48 units.

For Knowledge and Confidence about CLAS, the cost to achieve a 1-point improvement (or 20 percent improvement) was estimated to be $11,994 per participant. For Overall Cultural Responsivity, the cost to achieve a 1-point improvement (or 20 percent improvement) was estimated to be $18,989 per participant as shown in **Figure 6.4.**

FIGURE 6.4

COST PER UNIT IMPROVEMENT



PART 2: ECONOMIC EVALUATION OF THE ICCTM PROJECT OVERALL

The cost of the ICCTM Project totaled $5,774,554, which includes the cost of the contract with UC Davis CRHD and SCBH personnel expenses, but not costs related to the implementation of the community-defined quality improvement QI Action Plans.

The effectiveness measure, new consumers' shift from point of entry through crisis services to outpatient services, used data on 5,689 consumers who had a first admission to SCBH's system of care during a 39-month period encompassing ICCTM activities (July 1, 2017 through September 30, 2020).

Cost of the ICCTM Project Overall

The overall cost of the ICCTM Project over a 5-year period (across 6 fiscal years) was calculated based on actual expenditures to be just under $5.8.

Figure 6.4 summarizes those costs by year and the type of costs including:

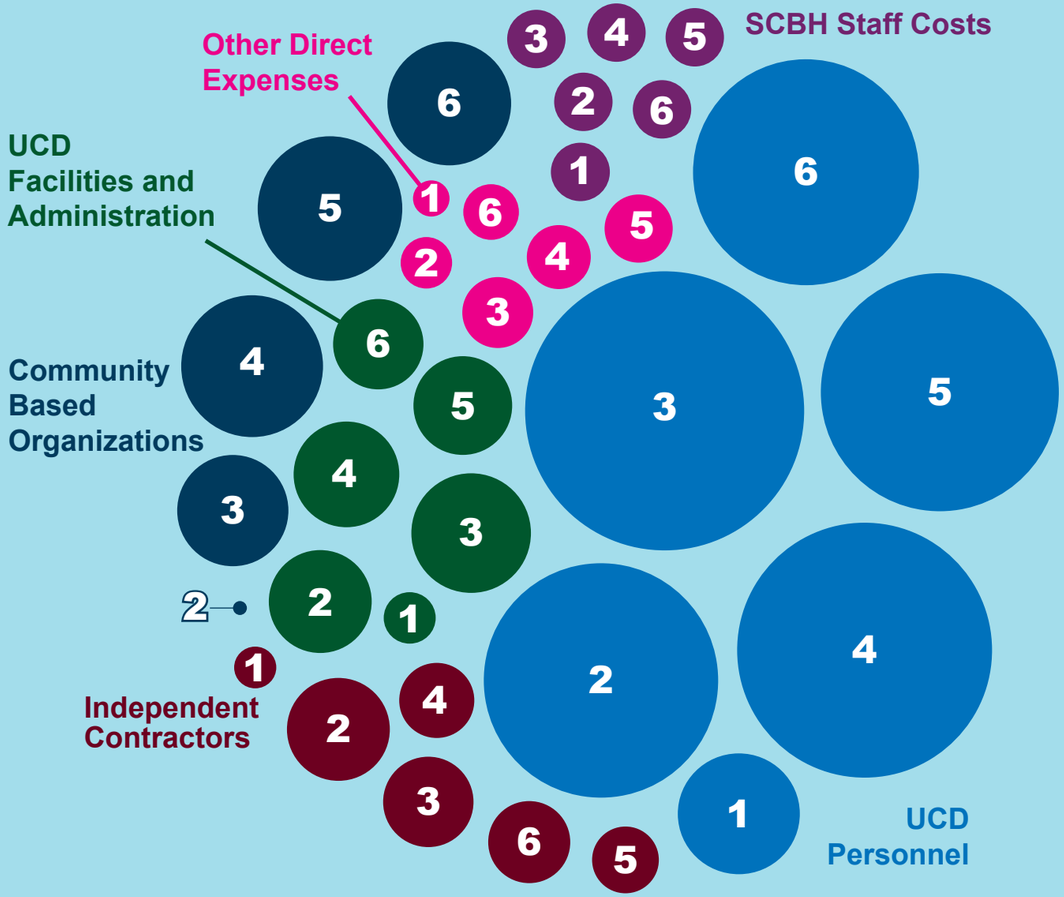
- UCD personnel expenses (salary and fringe benefits)
- Two independent contractors
- SCBH staff cost
- Contracts with three Community-Based Organizations
- UCD facility and administrative (i.e., overhead or indirect costs)
- Other direct expenses

The largest cost category was Personnel, accounting for $3.50 million. This included the cost of specialists related to the planning, implementation, and evaluation of the Solano Project, as well as the cost of staff for the delivery of the Providing Quality Care with CLAS Training Program.

Specialists for the ICCTM Project also involved a project manager, community engagement coordinator, program implementation and sustainability coordinator, and an evaluation coordinator, all who had training at either a master's (e.g., MPH) or doctoral (PhD) level.

Community engagement represents a key feature of the ICCTM Project. As such, the cost of the ICCTM Project included partnerships with three community-based organizations (CBO), each with expertise in outreach with each of the three communities of focus for the ICCTM Project: Filipino American, Latino, and LGBTQ+ groups. Each CBO was responsible for developing and implementing workplans to

FIGURE 6.4 ICCTM PROJECT COSTS BY TYPE AND FISCAL YEAR



engage in outreach and assist with achieving community-level goals. This included health education activities, convening support groups, and recruiting members of the community to help serve as key informants for the ICCTM Project and guide its efforts.

Effectiveness of the ICCTM Project Overall

One of the goals of the ICCTM Project was to shift the point of entry for consumers' first admissions away from crisis care to care in the outpatient setting. Therefore, the proportion of behavioral health service users who had their first admission through outpatient services versus crisis services was examined. Evidence of improvement was defined as a decreasing proportion of consumers with first admissions who entered the system of care through a crisis service program.

Data on point of entry was obtained from Solano County's Avatar electronic health record (EHR) system and included all records when consumers utilized a SCBH service between July 1, 2015 and September 30, 2020. Each record provided the date a consumer utilized a service, the description of the type of service used, as well as an admission date associated with the consumer's most recent episode (consumers may have multiple service use episodes over time).

When examining the potential influence of the ICCTM Project on outpatient and crisis service utilization among the communities of focus, we defined the following time periods for analysis:

- Pre-ICCTM: July 1, 2015 through June 30, 2017 (i.e., FY 15-16 and FY 16-17; 24 months)
- ICCTM Period: July 1, 2017 through September 30, 2020 (i.e., FY 17-18 through FY 19-20; 39 months)

Filipino American consumers experienced the largest improvement in the proportion or ratio of first admissions via crisis services, with a 14.6 percent reduction as shown in **Figure 6.5**.

The improvement or reduction in first admission via crisis services among Latino consumers was similar to that of White consumers at 8.4 vs. 8.1 percent, respectively. While Filipino American consumers did have the largest improvement, their ICCTM period ratio is similar to that of White consumers (36 vs. 37 percent), but the ICCTM period ratio for Latino consumers was more than 10 percent points better than both.

Among Filipino American consumers, 84 individuals had their first admission date during FY 15-16, among which 40 (47.6 percent) of were through crisis services rather than outpatient services.

Among Latino consumers, 503 individuals had their first admission date during FY 15-16, among which 154 (30.6 percent) were through crisis services rather than outpatient services. The frequency of having their first admission via crisis services decreased from 30.6 percent in FY 15-16 to 26.5 percent in FY 18-19. Among Filipino American consumers, the frequency of having their first admission via crisis services decreased from 47.6 percent in FY 15-16 to 37.7 percent in FY 18-19.

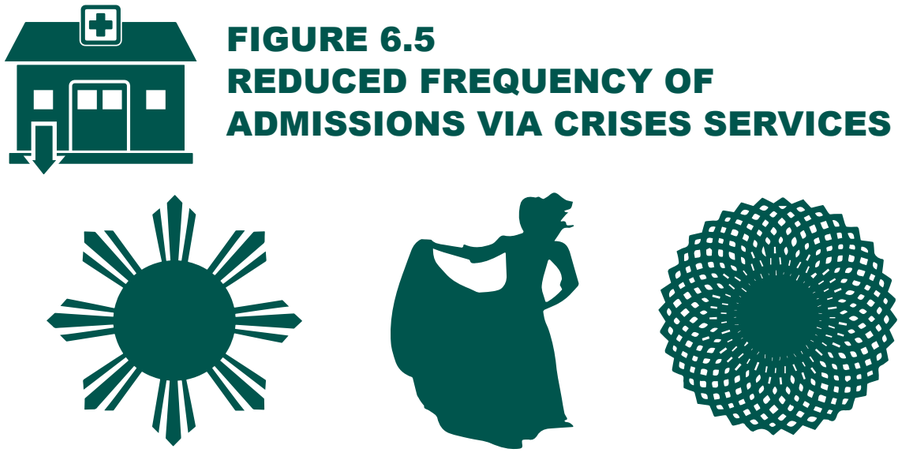
The LGBQ+ group experienced the a 7.6 percent improvement in first admission via crises services dropping from 43 percent in before ICCTM to 35.4 percent in the ICCTM period. The non-cisgender group experienced the largest improvement in the proportion or ratio of first admissions, with a 22.7 percent improvement. The improvement for the cisgender group was also large at 11 percent improvement.

For our analyses, we assumed that the total group for whom we could see outcomes in the ICCTM period would be 5,689 people. This is important because the ICCTM costs are spread over those 5,689 people and the improved outcome rates are applied to this group as well.

Cost-Effectiveness for the ICCTM Project Overall

The total cost for the ICCTM Project, $5,774,554, spread over the 5,689

FIGURE 6.5
REDUCED FREQUENCY OF ADMISSIONS VIA CRISES SERVICES



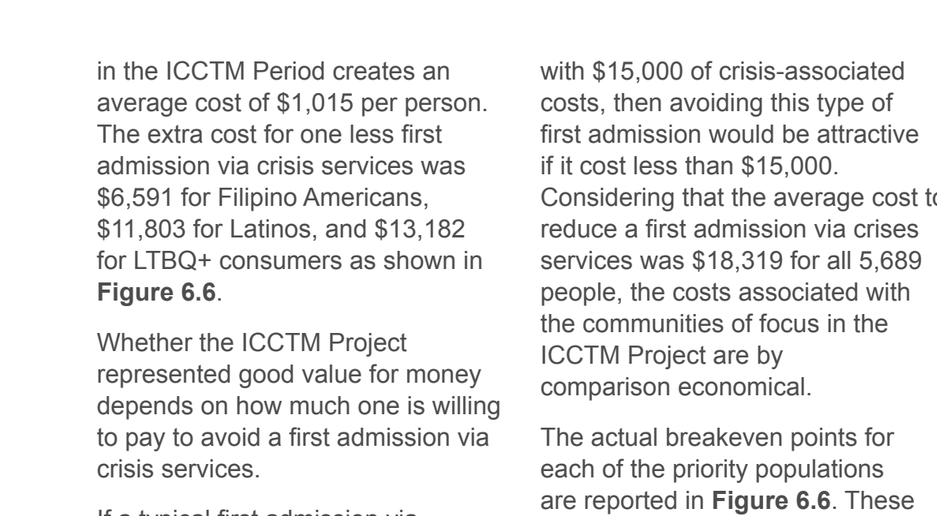
in the ICCTM Period creates an average cost of $1,015 per person. The extra cost for one less first admission via crisis services was $6,591 for Filipino Americans, $11,803 for Latinos, and $13,182 for LTBQ+ consumers as shown in **Figure 6.6**.

Whether the ICCTM Project represented good value for money depends on how much one is willing to pay to avoid a first admission via crisis services.

If a typical first admission via crisis services was associated with $15,000 of crisis-associated costs, then avoiding this type of first admission would be attractive if it cost less than $15,000. Considering that the average cost to reduce a first admission via crises services was $18,319 for all 5,689 people, the costs associated with the communities of focus in the ICCTM Project are by comparison economical.

The actual breakeven points for each of the priority populations are reported in **Figure 6.6**. These breakeven points are realized when the benefits of reducing the cost of first admission via crises services outweigh the costs of programs developed through the ICCTM Project for the community.

FIGURE 6.6
COST TO REDUCE ADMISSIONS VIA CRISES SERVICES BY COMMUNITY OF FOCUS



CONCLUSION

The Economic Evaluation of the ICCTM Project estimated the cost-effectiveness of the project overall and presented a separate cost effectiveness estimate of the Providing Quality Care with CLAS Training Program component.

Decision makers should consider these analyses in determining if ICCTM efforts are cost-effective relative to the extra value. In the case of the CLAS Training Program, the cost was approximately $465,000 and the extra effects were modest improvements (10-15 percent) in participants' knowledge and confidence about the CLAS standards and their overall cultural responsivity.

In the case of the ICCTM Project Overall, at a cost of $5.7 million, the cost of preventing a single first admission via crisis services across the ICCTM communities of focus was estimated to be less for all three communities of focus than the population in general.

To prevent a first admission via crisis services for a single Filipino American consumer, SCBH may expect to spend approximately $7,000, approximately $12,000 for Latinos and approximately $13,000 for LGTQ+ consumers. The UCD CRHD recommends that this economic evaluation be viewed in the context of all the other program results and within the ICCTM's intent to impact the Quadruple Aims: consumer experience, provider experience, health care access and utilization, and cost-effectiveness.

Beyond its cost-effectiveness, there may have been many other benefits and considerations that were less tangible but nevertheless make the ICCTM Project economically attractive including improvements in consumer experience as described in chapter 4, which were not evaluated as part of this economic analysis.

Counties where communities and decision makers investing in transforming culture, improving cultural responsivity and practicing high levels of community engagement may decide it is well worth pursuing the ICCTM model further.

The ICCTM Project is an ambitious program that has gained strong footing in Solano County but continues to evolve and grow. Future efforts related to the ICCTM Project can use the information here to develop strategies, including some to lower program costs.

7 COMMUNITY ENGAGEMENT

INTRODUCTION

SCBH partnered with UC Davis CRHD to launch the ICCTM Project to improve access and utilization of mental health services among Filipino American, Latino, and LGBTQ+ communities.

To meaningfully engage with these communities, SCBH and UCD CRHD partnered with leading local community-based organizations (CBOs) that had expertise and standing with each of those communities. Partnerships aimed to enhance community outreach and meaningful engagement to increase capacity and effectiveness in culturally relevant and linguistically appropriate mental health services by:

- Reducing the stigma of mental health
- Promoting wellness
- Helping to identify and connect those in need of services to treatment

Outreach is important in promoting wellness and culture, but authentic engagement is needed to help identify those who are not fully utilizing available mental health services. With the right partnerships, empowered communities can build trust to connect people to the treatment that they need.

UCD CRHD partnered with three trusted community-based organizations, Fighting Back Partnership (FBP), Rio Vista CARE (RVC), and Solano Pride Center (SPC). Each brought with them experience and expertise in working with the three communities of focus and worked with UCD CRHD and Solano County to implement the ICCTM Project.

Community members were empowered to lend their voice by sharing their concerns with SCBH and offering ideas for building trust with the community and inclusive initiative that supported the ICCTM objectives. This information was then used as part of the project to address access and utilization of services with a cultural and linguistic lens.

UCD CRHD relied heavily on the expertise and standing that all three CBOs had in Filipino American, Latino and LGBTQ+ populations across seven cities of focus: Benicia, Dixon, Fairfield, Rio Vista, Suisun, Vacaville, and Vallejo.

The five key objectives of the work the CBOs would do in support of the project included:

1. Enhance community outreach and engagement efforts in Filipino American, Latino, and LGBTQ+ communities
2. Support the implementation of QI Action Plans by engaging with communities

3. Facilitate communication and collaboration between SCBH and community
4. Participate in CLAS Training as part of the ICCTM Project
5. Demonstrate incorporation of the CLAS Standards into their policies, programs, and practices

To support the CBO partners, UCD CRHD provided training and resources such as:

- Trained each CBO on Community Based Participatory Research principles
- Developed a customizable training curriculum for Mental Health 101 for them to use in the community and trained them on how to present on those topics
- Set up a project retreat to learn about health disparities and the Principles of Community Engagement
- Provided them with a workshop to develop a workplan and a set of measurable goals and objectives
- Assisted them with continued resources and mental health outreach supplies through Each Mind Matters
- Set up bi-weekly project check-ins to help identify issues and problem solve
- Included monthly project check-ins with all project leaders and staff to brainstorm on best practices
- Kept their Board of Directors updated with project progress and objectives

The following section provides information about each CBO workplan and the goals that they set out to accomplish for their respective community of focus. In an effort to build stronger partnerships, all three CBOs decided to also create a combined workplan to address the needs of intersectionality between Filipino American, Latino, and the LBGTQ+ communities.

Rio Vista CARE Workplan Goals

Global Goal 1: Raise mental health awareness and education in the Latino Community.

- Provide basic mental health presentations to the Latino Community in Solano County to promote information about mental health wellness and connect them to county mental health services.
- Partner with medical entities and their clinical staff to coordinate education presentation and “platicas comunitarias” focused on mental health topics among Latinos
- Partner with SCBH and NAMI Solano to coordinate support groups for the Spanish speaking Latino Community in Solano

Global Goal 2: Enhance community outreach and engagement efforts in the Latino community to ensure early access to mental health services and reduce stigma.

- Collaborate with cities, and organizations that celebrate Latino cultural events throughout Solano County to encourage community engagement opportunities to discuss Latino culture/ identity/history as a strategy for wellness and prevention
- Develop partnership with countywide Head Start Programs and State Pre-schools to increase mental health outreach at preschools and raise awareness among parents, and teachers
- Partner with community clinics to provide presentation for their Latino consumers and providers to increase knowledge/ awareness of mental health wellness and services/resources

Fighting Back Workplan Goals

Global Goal 1: Enhance community outreach and engagement efforts in the Filipino American communities by raising awareness, talking about stigma, and talking about barriers to access to care.

- Establish a coalition of Filipino American community members committed to reducing the stigma of mental health in the Filipino American community. The Filipinx Mental Health Initiative (FMHI)- Solano was launched in fiscal year 2018/19
- Develop and manage a social media page to promote the ICCTM Innovation Project and FMHI-Solano
- Develop locally focused education materials on Filipino American mental health
- Facilitate workshops focusing on Filipino American identity, history, culture, etc. for youth to combat stigma and raise awareness about mental health

Global Goal 2: Facilitate and foster communication and collaboration between: a) Solano County and the three communities of focus and b) Solano County and CBOs in seven main cities.

- Partner with KAAGAPAY, SCBH's Filipino American outreach program, to coordinate mental health awareness activities for the Filipino American community
- Work with county and city policymakers to obtain a proclamation that establishes one week in May as Filipino American Mental Health Week.

Solano Pride Workplan Goals

Global Goal 1: Establish a relationship between SPC and LGBTQ+ affirming faith-based organizations (specific intermediate goals, will be determined based on focus group results regarding partnership needs between faith organizations and SPC).

- Partner with already identified LGBTQ+ friendly affirming faith-based organizations to provide LGBTQ+ and Mental Health training to staff/leaders

Global Goal 2: Develop peer support groups for the family and friends of LGBTQ+ community members. (Specific intermediate goals, TBD based on a few events to gage community needs and resources).

- Develop and establish a peer support program for Latinx and Filipinx family and friends of LGBTQ+ community members

Global Goal 3: Establish an alliance mental health and LGBTQ+ senior program.

- Partner with already identified LGBTQ+ friendly affirming faith-based organizations to provide LGBTQ+ and Mental Health training to staff/leaders

CBO Joint Workplan: Pride People of Color (PPOC) Goals

Global Goal 1: Regularly collaborate to develop, share, and implement strategies to increase access to and utilization of mental health services by the three communities of focus in Solano County.

- Facilitate a PPOC (Pride People of Color) space in partnership with SPC
- Create a Queer Trans People of Color (QTPOC) support group
- Develop marketing and outreach materials that are comprehensive of the SCBH's ICCTM Innovations Project
- Coordinate a stigma-reduction project once a year, as determined by the CBO Project Coordinators (examples include campaign, movie screenings, Mental Health Month celebrations, etc.)

CBO WORKPLANS

The next section details each workplan's key accomplishments, partnerships, outreach and engagement efforts in their respective communities, and trainings.

It is important to note that the ICCTM Innovations Project faced unprecedented challenges during the time of COVID-19. The CBO teams responded by continuing outreach and engagement virtually

KEY ACCOMPLISHMENTS

PARTNERSHIPS

COMMUNITY EVENTS (OUTREACH)

and using social media as an outlet to continue maximizing messaging. As a result, this report describes the unique innovative approaches such as cultural story-telling narratives to link communities to Solano County services.

Readers may find encouragement to begin replicating these type of community outreach and engagement efforts in other counties with the ultimate goal to improve mental health for each county's communities of focus.

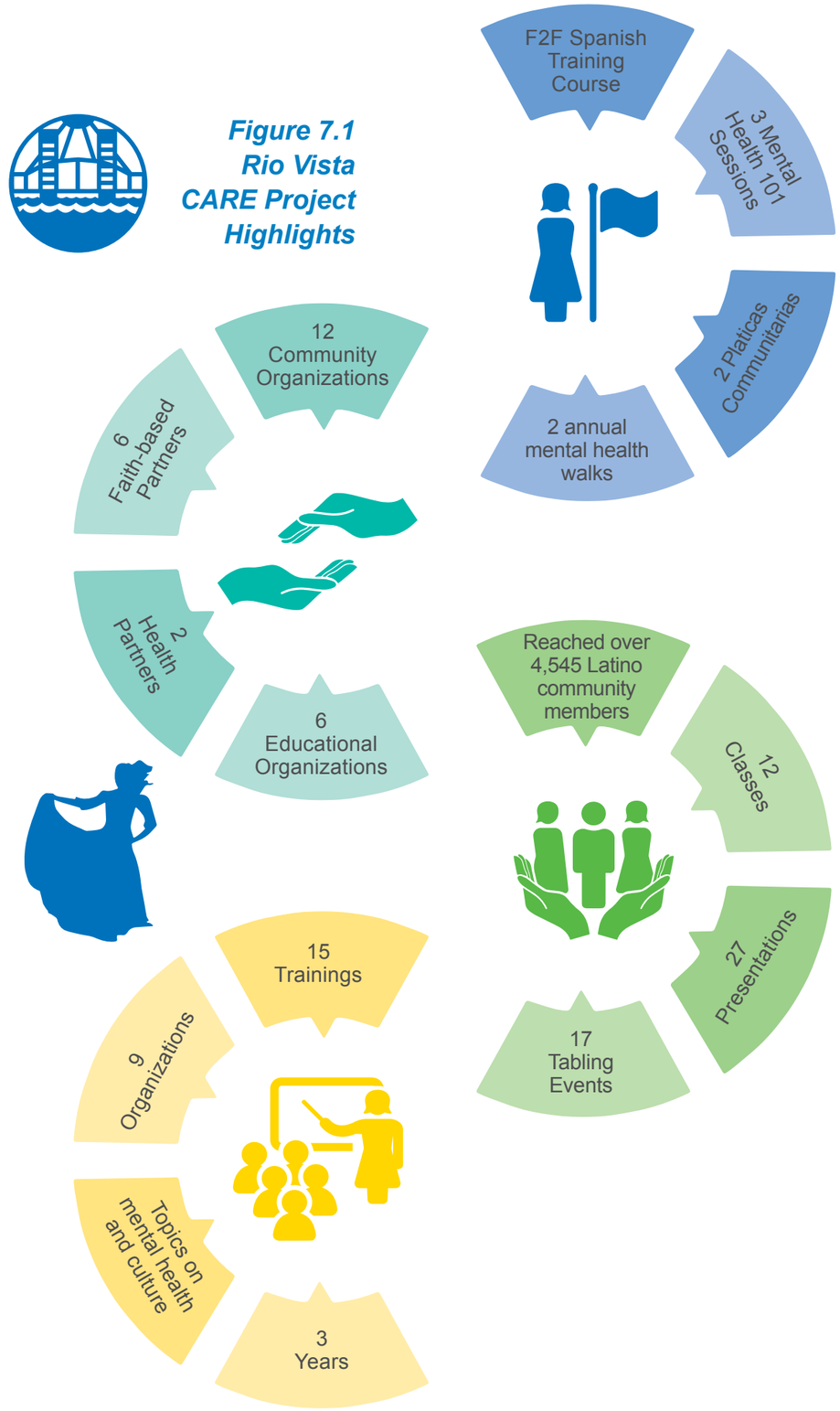
LEADING COMMUNITY PARTNER: RIO VISTA CARE, INC (RVC)

RVC is the only non-profit mental health counseling and family resource center serving the youth and families of the lower Sacramento Delta region, which includes Solano County jurisdiction, with the capacity to provide on-site access to comprehensive prevention and treatment services for families, children, youth, and adults. RVC serves as a vehicle for engaging the Rio Vista community and surrounding rural areas. The Meet and Greet to begin the partnership between, SCBH, UCD CRHD, and RVC, was on August 2017, in RVC. A summary of the RVC workplan is presented in **Figure 7.1.**

Key Accomplishments

RVC's workplan goal was to promote wellbeing and break stigma

Figure 7.1 Rio Vista CARE Project Highlights



surrounding mental health in the Latino community by raising awareness about available SCBH's mental health resources and services. Key accomplishments include:

- Provided the first National Alliance on Mental Illness (NAMI) Famila-a-Famila (F2F) Spanish training course in Spanish in Solano County
  - Graduated 5 Spanish speaking community members to become future certified F2F teachers in Solano County
  - This partnership will bring trained Spanish-speaking instructors who know what it means to have relatives living with mental illness
- Hosted over 3 Mental Health 101 educational sessions
  - Parent Center at Armijo High School
  - Mobile Mexican Consulate.
  - Fairfield-Suisun Unified School District – Healthy Start Family Resource Center
- Hosted 2 Platicas Communitarias
  - Rainbow Coalition Touro University
- Attended and provided outreach at over 15 community events to promote mental health resources and services
- Reached out to over 4,545 Latino community members and distributed over 500 ICCTM brochures
- Co-hosted 2 annual mental health walks in their city to bring awareness to suicide prevention efforts

- Hosted a Spanish Latino Community Forum to inform the community of the progress of the project and continue to seek community input with over 30 attendees

Partnerships

In this section, we list the community partnerships that RVC developed during their time on the ICCTM Project. These partnerships were needed to promote mental health and well-being across Solano County.

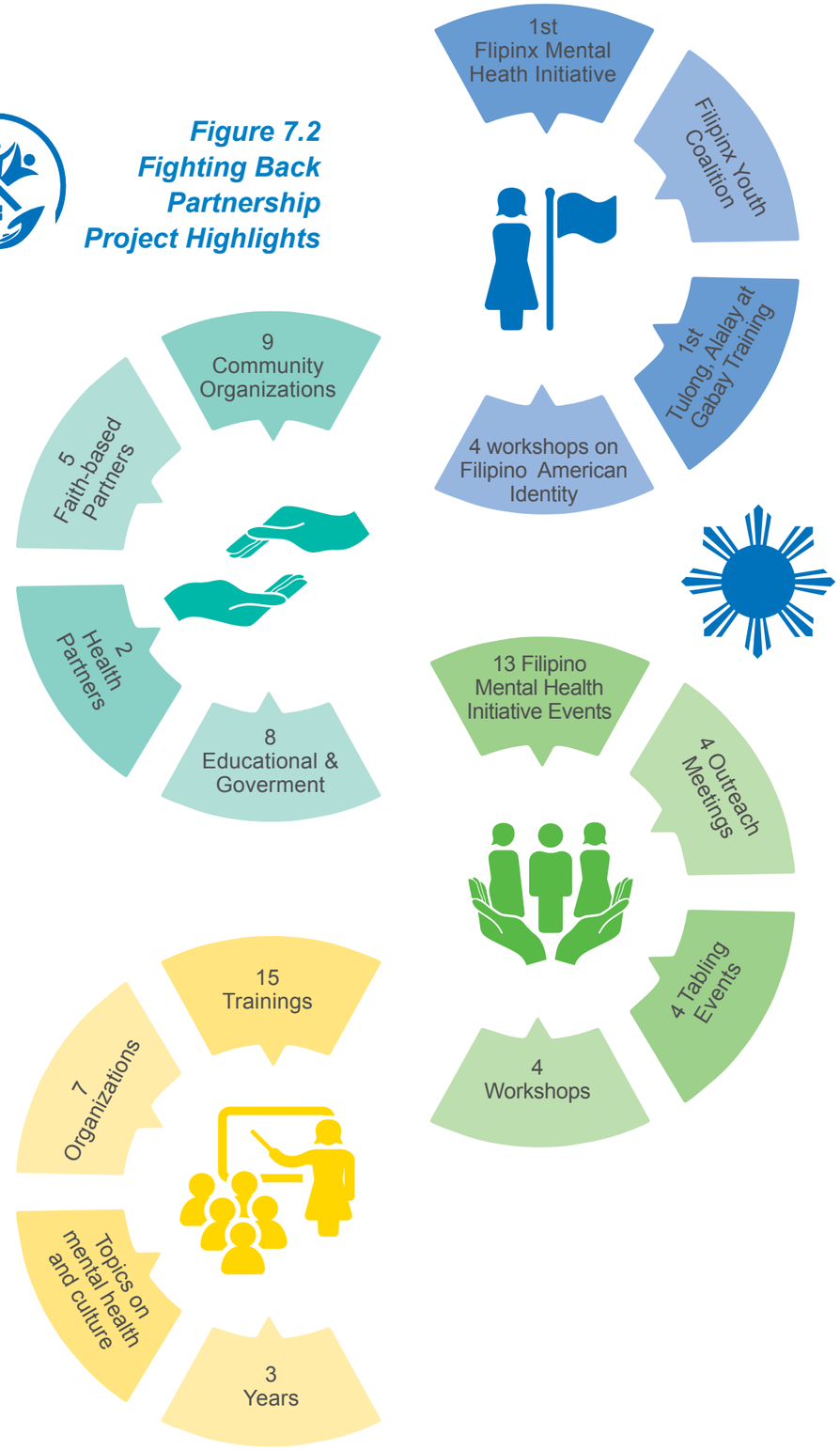
To implement the ICCTM Project with the Latino community, RVC used their expertise and relationships in the community and partnered with multiple organizations to increase awareness and reduce stigma.

- Community Organizations – 12
- Faith Based Partners - 6
- Educational Organizations – 6
- Health Partners - 2

Community Events (Outreach)

RVC was responsible for developing innovative processes of community outreach and engagement in the Latino communities. RVC was also responsible for developing innovative outreach activities that will help identify community members in need of services to connect them to services.

Figure 7.2 Fighting Back Partnership Project Highlights



In total, RVC connected with 4,545 people:

- 113 people at 12 Classes
- 322 people at 27 Presentations
- 4,360 people at 17 Tabling Events

Trainings

RVC staff demonstrated a strong commitment to continued learning and preparation to better support its community by attending 15 trainings on mental health and culture with 9 organizations over 3 years.

LEADING COMMUNITY PARTNER: FIGHTING BACK PARTNERSHIP (FBP)

FBP represents the Filipino American community as a nonprofit organization that is committed to preventing and ending poverty and its effects in Vallejo, California and throughout Solano County. FBP focuses on family strengthening, youth development, and civic engagement in public health initiatives. The Meet and Greet to begin the partnership between, SCBH, UCD CRHD, and FBP, was on January 9, 2018, at FBP.

A summary of the FBP workplan is presented in **Figure 7.2.**

Key Accomplishments

FBP's workplan goal was to promote wellbeing and breaking stigma

surrounding mental health in the Filipino American community by raising awareness about available Solano County mental health resources and services. Key Accomplishments include:

- Established and launched the FMHI-Solano Coalition in May 2019
    - A coalition of Filipino American community members committed to reducing the stigma of mental health in the Filipino American community
    - Developed a Filipinx Mental Health Initiative (FMHI-Solano) – Solano Newsletter to share with the community
- Created Filipinx Youth Coalition (FYC)
- Collaborated with Napa Valley USD Innovation Project to relaunch a coalition.
- Brought to Solano County the first Tulong, Alalay, At Gabay (TAG) Training, as funded by SCBH
    - TAG is a grassroots approach that educates communities to identify warning signs and symptoms of the most common mental health problems, to triage any actively suicidal person and connect them to professional help; TAG follows the simple format of Psychological First Aid by the World Health Organization and the Disaster Crisis Intervention program in San Francisco)
    - In addition to the TAG Training being provided for the community, several people were trained as trainers to be able to provide the TAG training which will help sustain this effort
- Developed and managed a social media page to promote FMHI - Solano
    - Created #UsapTayo (Let's Talk) Digital Story Telling in Solano County – filming sessions at FBP
    - Inaugural Facebook Post for #UsapTayo: Video Series Launch
- Hosted a movie screening on mental health and the Filipino-American community called 'Silent Sacrifices: The Voice of the Filipino American Family Documentary' at American Canyon High School
- Hosted a Filipino American Community Forum to update the community on the project and continue to seek their input with over 56 attendees
- Facilitated 4 workshops focusing on Filipino American identity, history, and culture to youth - the first workshop was conducted in October 2018 to the Filipino American high school club and the topic included Filipino American waves of migration to the United States and prevention strategies for mental health

Partnerships

In this section, we list the community partnerships that FBP developed during their time on the ICCTM Project. These partnerships were needed to promote mental health and well-being across Solano County. To implement the ICCTM Project FBP partnered with 24 organizations.

FBP's partnerships went beyond one-time collaborations and became a coalition of community members with the brand FMHI-Solano, a movement to improve mental health for Filipino Americans in Solano County. Please see organizations to follow.

- Community Organizations – 9
- Faith Based Partners - 5
- Educational Organizations – 5
- Health Partners – 2
- Government Agencies - 3

Community Events (Outreach)

FBP developed innovative processes for community outreach and engagement in the Filipino American community with pioneering outreach activities that helped identify community members in need of behavioral health services.

That work was followed by Community Forums to keep people informed about the project and its progress including:

- 1 Action Plan
- 13 FMHI-Solano with SYC
- 1 Lecture
- 4 Outreach Meetings
- 3 Presentations
- 2 Social Events
- 4 Tabling Events
- 1 Wellness Fair
- 4 Workshops

Trainings

FBP demonstrated a strong commitment to continued learning and preparation to better support its community by attending 15 trainings on mental health and culture with 7 organizations over 3 years.

LEADING COMMUNITY PARTNER: SOLANO PRIDE CENTER (SPC)

SPC is a community based nonprofit organization that welcomes anyone who wishes to work toward an inclusive community for all, regardless of sexual orientation or gender identity. SPC is a resource center geared towards improving the lives of the LGBTQ+ community in all of Solano County through community engagement, peer support groups, counseling, and social gatherings and events.

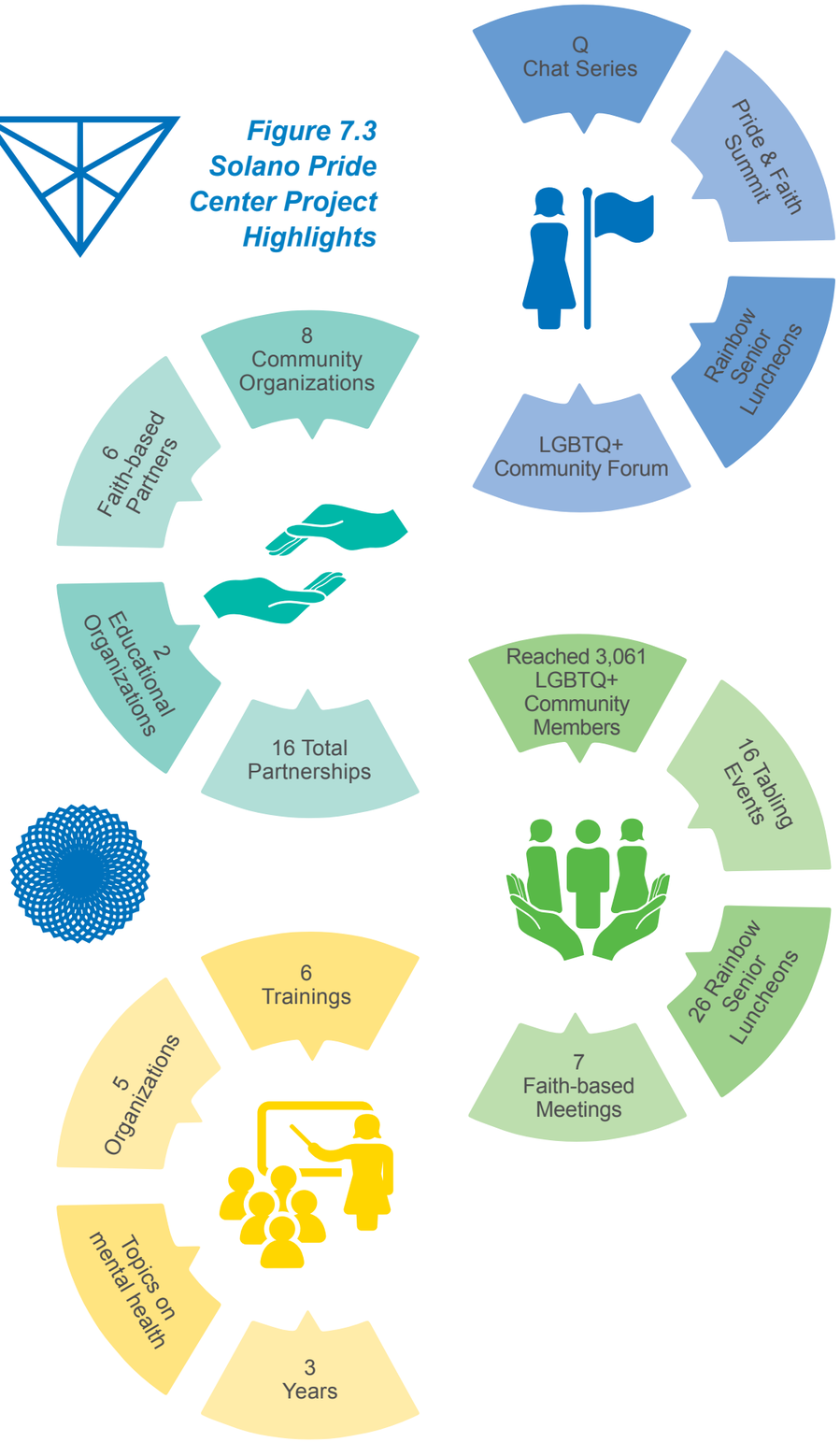
A summary of the SPC workplan is presented in **Figure 7.3.**

Key Accomplishments

SPC's workplan goal was to promote wellbeing and breaking stigma surrounding mental health in the LGBTQ+ community by raising awareness about available Solano County mental health resources and services. The Meet and Greet to begin the ICCTM partnership was held at the SPC on January 9, 2018. Key accomplishments include:

- Created Q Chat Series:
  A discussion on intersectionality, religion, being LGBTQ+, mental health, and other topics important to the LGBTQ+ community
- Hosted the Pride & Faith Summit at St. Paul's Episcopal Church in Benicia, CA

Figure 7.3 Solano Pride Center Project Highlights



  - SPC partnered with already identified LGBTQ+ friendly affirming faith-based organizations to provide LGBTQ+ and mental health training to faith-based staff/leaders.
- Partnered with Faith in Action to host Rainbow Senior Luncheons and Book Club.
  - Established a LGBTQ+ group/ safe space sponsored by SPC and established staff and faculty to sustain the group
- Hosted the LGBTQ+ Community Forum to provide the community with project updates and continue to seek their input, with 24 attendees
- Developed and established a peer support program for Latinx and Filipinx family and friends of the LGBTQ+ community
- Supported the implementation of CLAS Quality Improvement (QI) Plans/Efforts important to the LGBTQ+ community such as LGBTQ+ Ethnic Visibility Posters

Partnerships

This section lists community partnerships that SPC developed during their time on the ICCTM Project. These 16 partnerships were needed to develop peer support groups for parents to:

- Discuss risk factors associated with mental illness (stigma, discrimination, and isolation)

- Promote culture and inclusivity, mental health wellness for the LGBTQ+ community
- Affirm partnerships between faith-based organizations and the LGBTQ+ community in Solano County

Partners included:

- Community Organizations – 8
- Faith Based Partners - 6
- Educational Organizations – 2

Community Events (Outreach/Engagement)

SPC was responsible for developing innovative processes of community outreach and engagement in the LGBTQ+ community.

SPC staff were also responsible for developing innovative outreach activities that helped identify community members in need of services to connect them to services, followed by community forums to keep them informed about project progress.

SPC participated in 74 events and provided mental health outreach to 3,061 people.

- 3 LGBTQ+ community events
- 15 people at 2 focus groups
- 58 people at 2 LGBTQ+ community forums
- 53 people at 2 lobbying activities for LGBTQ+ rights
- 273 people at 26 Rainbow Senior Luncheons
- 30 people at 7 Faith-based Meetings
- 163 people at 6 Presentations
- 105 people at 7 Q-Chat Series
- 20 people at 1 Pride & Faith Summit
- 2,320 people at 16 Tabling Events
- 24 people at 4 Virtual Luncheons

Trainings

SPC demonstrated a strong commitment to continued learning and preparation to better support its community by attending 6 Trainings by 5 Organizations over 3 years.

JOINT CBO GL0OBAL GOAL: PRIDE PEOPLE OF COLOR (PPOC)

SPC led a joint initiative to develop, promote, and coordinate a safe space specifically for people of color who identify as queer and/or trans in Solano County.

The global goal is to have an impact on wellness for Latinx and Filipinx who identify as LGBTQ+, for example, the **Annual Mental Health Stigma-Reduction Project**, a county-wide stigma-reduction collaboration project between SPC, FBP, and RVC. Major highlights for PPOC during ICCTM included:

- Conducted a total of three focus groups (25 total participants) to discuss issues affecting LGBTQ+ people of color and the impact the issues have on mental health and wellness
- Screened movie: Empowering documentary ‘El Canto Del Colibri’ followed by writing activities to allow people to personally reflect on the impact of coming out to their families (16 total participants)
- Provided feedback on the LGBTQ+ Ethnic Visibility QI Action Plan regarding messaging and distribution
- Partnered with the Rainbow Coalition at Touro University - as a result, 2 PPOC Pizza & Game Nights were created with (14 total participants)

CONCLUSION

The overall goal of the ICCTM Project was to improve mental health access and quality of care for the three communities of focus in Solano County.

The ICCTM model was successful in developing partnerships that gathered input from the community, and incorporated the National CLAS Standards for implementation and quality improvement of mental health services in Solano County.

As experts in their respective community, each CBO successfully connected Filipino Americans, Latinos and LGBTQ+ community members to mental health services in Solano County through outreach and engagement and SCBH recognized the importance of partnering with CBOs to outreach and engage with the communities of focus.

These partnerships helped play a key role in improving the relationships between County and the three communities of focus as well as the CBOs. The use of culture and health values was important to build trust, awareness, and confidence in Solano County Mental Health services.

The CLAS Training provided by UCD CRHD was well received across sectors, and the ICCTM Model brought innovative ways to partner, outreach, and engage with communities to better access and utilize Solano County mental health services for those who need it most.

8
SUSTAINABILITY

INTRODUCTION

The ICCTM Project altered the approach to providing mental health services in Solano County by focusing on three components as shown in **Figure 8.1:**

1. Community Engagement
2. CLAS Standards
3. Developing QI Action Plans & Sustainability

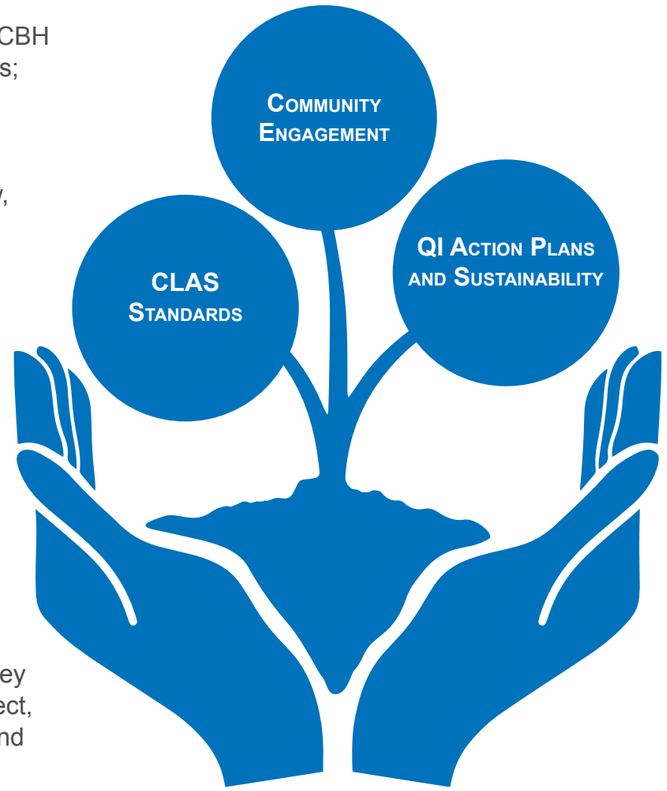
These three components fundamentally changed how SCBH provides mental health services; ranging from what consumers see when walking into a clinic and how they are treated, to policy development and review, contracting, and procurement processes throughout the SCBH Division.

These components have supported the evolution of perspectives for participants: consumers, community advocates, Community Based Organizations (CBOs) partners, SCBH staff, and representatives from other Solano County Health and Social Services Divisions.

Community engagement is a key component of the ICCTM Project, from the onset of the Project and throughout each phase of the Project. The project started by gathering community input from each community of focus.

By engaging, listening, and responding to community identified needs, accomplishments have been more meaningful and sustainable over time. During phase 1, UCD CRHD gathered community voices from the three communities of focus: Filipino American, Latino, and LGBTQ+.

Figure 8.1
Three Components of ICCTM Project



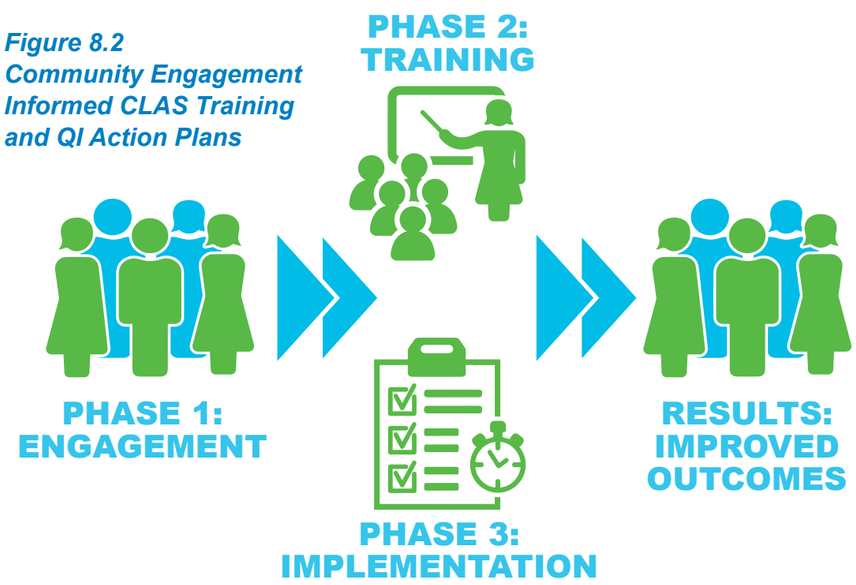
Input from the community is carried forward throughout the project as seen in the tailored training and QI Action Plans developed during Phase 2, and throughout the implementation process in Phase 3 as shown in **Figure 8.2.**

Another aspect of community engagement enlisted the support of three CBOs as community brokers and experts for engaging with each community. Participants in the CLAS Training were recruited from a wide range of backgrounds such as community members and advocates, Faith Based Organizations, Law Enforcement, CBOs, Public Health, Child Welfare and SCBH; intentionally engaging partners who also represeted the three communities of focus.

Within the training curriculum, community voices were shared with participants who built QI Action Plans to address the issues following the principles of the CLAS Standards.

Small groups of participants came together to develop concepts for system wide changes, ground in the CLAS Standards, with the intent of transforming mental health service delivery in Solano County. This training program culminated in 10 QI Action Plans, developed by community, for community and based on community input.

Figure 8.2
Community Engagement Informed CLAS Training and QI Action Plans



ICCTM PROJECT LONGEVITY

This section of the report describes some of the products of the ICCTM Project and opportunities for sustainability. The quality improvement section outlines SCBH's accomplishments to sustain the QI Action Plans and provides additional suggestions for future sustainability.

SCBH invested a considerable amount of time and money to funding the education from the CLAS Training and subsequent QI Action Plans to create long-term systems change driven by community. Rigorous comprehensive program evaluation conducted by the UC Davis CRHD accompanied the ICCTM Project during every phase.

To further sustain the critical work that began with the ICCTM Project, CHRD pulled together resources, recommendations and tools for SCBH's continued journey towards providing community identified, culturally and linguistically oriented mental health services throughout Solano County. The evaluation and project resources summarized here are intended to help SCBH further elaborate, scale, replicate, and sustain essential components of the ICCTM.

A list of organizations and foundations has been compiled for potential funding opportunities, along with interactive links.
To round out this sustainability report, the final section provides an overview of SCBH leadership input on sustainability along with lessons learned.

Quality Improvement Plan Sustainability

Since the beginning of the project, SCBH committed to the ICCTM process by encouraging and supporting community engagement. That served as the foundation for the rest of the project, from the tailored training to the development of the QI Action Plans as shown in **Figure 8.2.**

A transition report prepared by CRHD served as SCBH's guide to honor the vision and goals of the QI Action Plans during their implementation and long-terms. With the participants trained, and the QI Action Plans developed, SCBH committed to implementing the ten QI Action Plans

The ten QI Action Plans are presented on each of the next ten pages, with each summarized according to the following 6 themes:

1. Vision
2. Goal
3. Proposed Intervention
4. Plan Components
5. Implementation Accomplishments
6. Opportunities and Sustainability

QI-1: “LGBTQ+ ETHNIC VISIBILITY” - SIGNAGE CAMPAIGN

VISION

Create a culture of celebration of the richness of diversity within Solano County.

GOAL

Increase visibility in mental health for LGBTQ+ Filipino American and LGBTQ+ Latino communities.

INTERVENTION

Create culturally and linguistically appropriate signage to increase visibility of these groups.

PLAN COMPONENTS

LGBTQ+ Filipino American and Latino signage.

IMPLEMENTATION ACCOMPLISHMENTS

This team held several rounds of focus groups with both the LGBTQ+ Filipino American and the LGBTQ+ Latino communities to develop messaging and imagery for the signage campaign. They developed and distributed seven posters depicting the LGBTQ+ Filipino American and LGBTQ+ Latino communities throughout Solano County. More than 450 have been provided to stores, businesses, restaurants, wellness centers, and healthcare and mental health clinics.

QR codes and web-shorterners were included on each poster and when used community members will be navigated to SCBH’s website and to a specific page created for the LGBTQ+ community which includes local resources, the SCBH Access Line and crisis hotlines/text lines.

OPPORTUNITIES AND SUSTAINABILITY

Additional posters were printed and are in the process of being distributed throughout Solano County. SCBH continues to work with the Transgender community to create poster representing the Transgender Filipino American and Latino communities. Additionally, SCBH has expanded this project to include the LGBTQ+ African American and Native American communities. Focus groups for these communities are being planned.

With this community engaged process established from development to printing, CRHD recommends revisiting this process to continue to develop other signage and/or materials reflective of Solano County communities and needs.

QI-2: “TAKIN’ CLAS TO THE SCHOOLS” - SCHOOL-BASED WELLNESS CENTERS

VISION

Create mental health wellness centers in schools throughout Solano County.

GOAL

Increase access and utilization of mental health services by providing clinical services at school-based wellness centers.

INTERVENTION

Open a total of five pilot school-based wellness centers with the option of having a clinical mental health provider available and possibility of opening additional wellness centers across Solano County.

PLAN COMPONENTS

Develop a wellness center implementation plan checklist. Identify partner school sites/districts who demonstrate readiness for school-based wellness centers.

IMPLEMENTATION ACCOMPLISHMENTS

SCBH in collaboration with the Solano County Office of Education (SCOE) established 45 School-Based Wellness Centers in K-12 and adult eduction sites across Solano County including the juvenile detention facility. Five of these sites opened and were available to students before the COVID-19 pandemic which resulted in school closures. These spaces were designed to be culturally inclusive for all students as the imagery and materials in the Centers represent Solano County’s culturally and linguistically diverse communities.

While the COVID-19 pandemic shut down schools and put strains on using these sites, SCBH and SCOE made the most of the time by planning for and ordering furniture and imagery to build out the sites for school reopening.

OPPORTUNITIES AND SUSTAINABILITY

SCBH and SCOE continue to partner to seek out other grant opportunities to sustain and augment the wellness centers including SCOE securing grant funds to co-locate interns in some of the Wellness Center sites. As long as funding is available, SCBH will continue to fund various partners to provide prevention and early intervention services and supports that can be leveraged by sites with Wellness Centers. Additionally, SCOE and SCBH continue to work in collaboration to help identity potential volunteer pools to staff the Wellness Centers.

QI-3: “TRUECARE PROMOTER” - RESOURCE ROADMAP

VISION

Support consumers and families through their mental health journey.

GOAL

Reduce stigma, and increase access, utilization, and retention for the Filipino American, Latino, and LGBTQ+ populations.

INTERVENTION

Create a mental health roadmap and peer navigator system to “hand hold” individuals through accessing services from start to finish.

PLAN COMPONENTS

Roadmap of mental health services and community resources and Peer Mental Health Navigator Program.

IMPLEMENTATION ACCOMPLISHMENTS

This team envisioned creating a community friendly resource guide of basic services that a community member may need such as behavioral health services, basic needs, crisis, and more . They took drafts of the map out to the community to get input on the types of resources and preferred look of the roadmap.

The group then worked with a graphic designer to create a map of meaningful resources and images representing Solano County’s diverse communities. The maps were developed in English, Spanish and Tagalog, and are available in paper versions as well as an interactive version in all three languages available on the SCBH website. Thousands of copies of these maps have been printed and are being distributed throughout Solano County in healthcare and behavioral health clinics, libraries, family resource centers, school wellness centers, transit centers, etc. The Solano County Public Health Promotores program is distributing the maps to community members they are serving. Additionally, these maps are being provided to individuals being released from both the juvenile detention facility and the adult jails. QR codes and web-shorterners were included on each poster and when used community members will be navigated to SCBH’s website and specifically to the Access page which includes the Access Line number and how to initiate services.

OPPORTUNITIES AND SUSTAINABILITY

While there was not funding available to implement the component of Peer Mental Health Navigators through SCBH, Solano County Public Health has hired 3 Navigators and have a pilot Promotores program which we work closely with to share resources. SCBH will continue to manage and update the Roadmaps created and are in the process of ordering these in a poster size for distribution and display in the locations listed above.

QI-4: BRIDING THE GAP” - OUTREACH STRATEGIES

VISION

Create an outreach strategy for individuals to learn more about mental health and the availability of services through promoting general wellness rather than discussing “mental health”.

GOAL

Change the way Solano County outreaches on mental health services and information in the community to slowly break down stigma associated with mental health.

INTERVENTION

Create a “wellness brand” that will be recognized throughout Solano County and expands outreach efforts to non-health related events throughout Solano County.

PLAN COMPONENTS

1) Wellness Outreach Brand

2) Outreach Strategies

IMPLEMENTATION ACCOMPLISHMENTS

This plan rebranded how mental health outreach is done at community events, focusing on outreach materials that emphasize wellness: mind, body, and spirit. Two products were developed 1) a Solano specific backdrop and 2) a wellness spinning prize wheel. The backdrop includes landscapes and landmarks from throughout Solano County and the wheel pieces cover a variety of topics such as physical fitness, nutrition and spirituality. People are asked non-invasive questions to provide a fun and interactive experience for community members to connect how these topics relate to mental wellness. Materials were developed in English, Spanish and Tagalog, and imagery represents diverse communities including the LGBTQ+ community.

OPPORTUNITIES AND SUSTAINABILITY

Both County and CBO partners will be able to use the materials developed for tabling events. Due to the COVID-19 pandemic the materials developed have not been able to be used. As such, SCBH engaged a creative design team specializing in the development of TV commercials and social media content to develop a multi-media campaign with a focus on wellness and representing the three communities of focus. Members of the QI Action Plan team participated in the creative design process. Nine (9) commercials were created; 3 in English, 3 in Spanish and 3 in Tagalog and 12 social media posts in all three languages were developed.

QI-5: “ISEEU” - CUSTOMER SERVICE AND INCLUSIVE SPACES

VISION

Change the mental health front office culture to always SEE consumers’ mental health care needs.

GOAL

Improve the customer service experience for consumers of diverse backgrounds to improve consumer satisfaction and likelihood of return for care.

INTERVENTION

Develop recommendations for improved cultural and linguistic competency and customer service trainings for mental health clinic front line staff that are linked to an ISeeU logo that customers recognize.

PLAN COMPONENTS

1) Front Line Staff Training Recommendations

2) ISeeU Branding Vision

IMPLEMENTATION ACCOMPLISHMENTS

A specialized ISeeU Training, as developed and delivered by UCD CRHD, geared towards frontline reception staff focused on customer service with a cultural lens was provided for three (3) cohorts with 51 participants representing both County and CBO staff. Training participants were able to weigh in on the design for the ISeeU logo used for the branding component of this QI Action Plan. SCBH has purchased and are in the process of distributing several hundred branded items such as lanyards, buttons, and stickers.

OPPORTUNITIES AND SUSTAINABILITY

This action plan envisions continued education of frontline staff on various topics identified by participants on an annual or biannual schedule. During FY 2021/21 SCBH funded several rounds of Behavioral Health Interpreter Training customized for frontline reception staff. This training included a section on how to access Language Link the vendor SCBH uses for interpreter services. At the end of the 2021 trainings, participants identified a number of topical areas for future trainings.

QI-6: “CULTURAL GAME CHANGERS” - DIVERSIFYING THE WORKFORCE

VISION

Have the diverse composition of Solano County reflected in the SCBH workforce now and for the future generations.

GOAL

Increase SCBH’s capacity to serve bilingual and bicultural consumers with a diverse workforce.

INTERVENTION

1) Create CLAS-appropriate strategies for recruitment and hiring

2) Recruit a diverse workforce through pipeline strategies in high schools

PLAN COMPONENTS

1) Human Resources Policies and Procedures Proposal

2) Mental Health Career Outreach Campaign Proposal

IMPLEMENTATION ACCOMPLISHMENTS

The QI Action Plan team developed an Inclusion Statement that is now included on all SCBH job postings for all levels of the organization. Additionally, the team in partnership with the Diversity and Equity Committee, developed diversity and equity-oriented questions for the screening and hiring process. While the pipeline component was put on hold, SCBH developed new brochures and outreach materials to support the pipeline and internship plan.

OPPORTUNITIES AND SUSTAINABILITY

For the human resources focus, continue to work towards adding language around diversity, equity, inclusion and culture and language into position descriptions at all levels of the organization. Identify and leverage school partnerships, as well as health academy pathways to participate in future career-oriented events.

QI-7: “CLAS GAP FINDERS” - SYSTEM MONITORING

VISION

Create a fully staffed unit that is dedicated to continuously identifying and addressing gaps in meeting CLAS Standards.

GOAL

Improve customer service and staff experiences through ensuring that SCBH is meeting CLAS Standards.

INTERVENTION

Develop a vision for the possible creation of a unit that can monitor and address gaps in SCBH compliance with CLAS Standards.

PLAN COMPONENTS

CLAS Standard Unit Development Vision

IMPLEMENTATION ACCOMPLISHMENTS

While SCBH has not been able to create an Equity Unit due to funding restrictions, there is a specific role called the Ethnic Services Coordinator and this person is responsible to assist the Division in monitoring our equity efforts and the implementation of the CLAS Standards. This plan focuses on monitoring the implementation of CLAS Standards within SCBH and contracted CBOs. Annually SCBH develops a Diversity and Equity Plan, and over the course of the ICCTM Project the CLAS Standards have been inserted into the Plan and are used as a guide for planning and monitoring the implementation of the CLAS Standards. Starting in fiscal year (FY) 2019/20 language was inserted into all contracts requiring funded partners to develop their own agency Cultural Responsivity Plans demonstrating their implementation of the CLAS Standards. During FY 2019/20 eleven (11) plans were submitted and seven (7) during FY 2020/21. In FY 2019/20 a new section “Cultural and Linguistic Considerations” was added to all new and renewed SCBH policies.

OPPORTUNITIES AND SUSTAINABILITY

Cultural Responsivity Plans create a mechanism to track and trend accomplishments by SCBH and CBOs to show the impact of this policy change for how mental health services are provided in Solano County. Prior to the development of this QI Action Plan, in FY 2016/17 SCBH implemented an annual Workforce Equity survey that is sent to all SCBH and CBO staff. This survey includes demographic questions as well as questions assessing for SCBH’s implementation of the CLAS Standards. This annual survey should be utilized to inform the annual review of progress and Plan goals. Additionally, SCBH is in the process of creating a comprehensive Equity Data Dashboard that will also be used to evaluate progress and areas of need.

QI-8: “CULTURALLY SENSITIVE SUPERVISION” - IMPROVE SUPERVISION PRACTICES

VISION

Improve relationships between clinical supervisors and their clinical supervisees using a highly interactive and lively process.

GOAL

Improve supervisors’ capacity and level of support to their multilingual and multicultural staff and consumers.

INTERVENTION

Train supervisors to perform culturally responsive supervision; and provide appropriate support, mentoring, and guidance to their staff on delivering multilingual and/or multicultural care to consumers.

PLAN COMPONENTS

1) Staff Survey of Clinical Supervisors and Supervisees, 2) Provision of a 2-day training delivered by Dr. Kenneth Hardy, 3) Rflective groups and consultations with Dr. Hardy, 4) Supervisor Log Alignment to Training Tenets

IMPLEMENTATION ACCOMPLISHMENTS

Training for clinical supervisors and managers on improving cultural and linguistic practices through supervision; and supervisors’ support of diverse clinical staff. SCBH brought in Dr. Kenneth Hardy who trained two cohorts, of 46 supervisors and managers on how to bring the topics of race and equity into clinical supervision. Additionally, coaching and consultation calls following the trainings were held to support trainees in processing and embedding the training tenants into their work. SCBH funded three (3) trainings provided by Dr. Hardy with a focus on trauma and the impact on marginalized communities, for direct line staff including one session that was designed for both non-clinical and clinical staff.

OPPORTUNITIES AND SUSTAINABILITY

SCBH plans to continue to contract with Dr. Hardy to provide both consultation and trainings as needed in order to continue the implementation of the tenants learned.

QI-9: "CULTURAL HUMILITY CHAMPIONS" - IMPROVE SYSTEM TRAININGS

VISION

Develop a workforce that is trained specifically in the cultural needs of their diverse consumer groups.

GOAL

Improve the customer service experience for Filipino American, Latino, and LGBQ and Transgender consumers by ensuring that clinical and non-clinical providers have basic knowledge about their cultural and language needs.

INTERVENTION

Develop a framework for culture-specific trainings for clinical and non-clinical staff to better understand the populations they are serving and develop recommendations for general training requirements for staff.

PLAN COMPONENTS

Training curriculum outlines for 1) Filipino American community, 2) Latino community, 3) LGBQ community, 4) Transgender community, 5) Training requirement recommendations

IMPLEMENTATION ACCOMPLISHMENTS

This plan focused on creating cultural humility trainings for SCBH staff and contracted CBOs including six different trainings related to diversity, equity and inclusion, and the system of care:

- *Diversity and Social Justice; Tulong (Help), Alalay (Assistance) and Gabay (Guidance); Behavioral Health Interpreter; Language Link; Filipino Core Values and Considerations in Culturally Responsive Care; and Cultural Psychiatry, Cultural Humility.*

Additionally, a series of videos were recorded:

- *Diversity and Social Justice, Language Link, and Filipino Core Values and Considerations in Culturally Responsive Care*

OPPORTUNITIES AND SUSTAINABILITY

Three recorded trainings are available online. The CRHD recommends that SCBH provide additional training opportunities for Latino, LGBQ+ and Transgender communities through in-house or contracted services. If developing the trainings in house, consider bringing together a workgroup made up of community members to create the outline and content for these trainings.

QI-10: "MENTAL HEALTH EDUCATION" - TRAINING FOR FAITH-BASED ORGANIZATIONS

VISION

Create stronger ties between SCBH and faith-based organizations through the education of youth ministries and faith leaders.

GOAL

Change the way faith-based organizations discuss mental health to decrease stigma and increase referrals to services.

INTERVENTION

Develop workshop(s) and mental health training for youth and faith leaders to help them help their members.

PLAN COMPONENTS

1) Youth mental health workshops; and 2) Mental health training for faith leaders

IMPLEMENTATION ACCOMPLISHMENTS

The QI Action Plan team developed an initial workshop entitled Let's Talk About Mental Health! focusing on the intersection of social media and mental health. Materials developed for this workshop include: 1) an agenda, 2) a slide deck with facilitator notes, instructions, and background information, 3) a pre and post-test for the workshop, 4) a pre and post-test question bank, and 5) a workshop evaluation. SCBH began contracting with vendors with a plan to provide training-for trainers (T4T) for Mental Health First Aid, safeTALK and Applied Suicide Intervention Skills Training (ASIST) for faith leaders to be scheduled for the spring of 2020, however due to the COVID-19 pandemic these trainings had to be canceled. The T4T trainings are not provided virtually, therefore this delayed the full implementation of this QI Action Plan. SCBH was able to fund LivingsWork Faith on-line trainings for 25 faith leaders which is in the process of being distributed to faith leads.

OPPORTUNITIES AND SUSTAINABILITY:

SCOE led the development of a Faith and Education Collaborative supported by SCBH to find ways for faith partners to support schools and to develop a volunteer base for the School-Based Wellness Centers. This provides an opportunity for an intersection of two of the QI Action Plans. Additionally, there is an opportunity to Identify community friendly locations to host workshops and trainings. Work with the KAAGAPAY/API and HOLA coordinators as cultural brokers to support youth workshops. Work with the mental health curricula companies and hold a training to share with interested clergy. Use evaluations from the youth workshops to identify future topics. Refer to the document Best Practices for Faith Based Organizations and Youth Ministries for strategies when working with youth ministries and faith organizations.

General Recommendations about QI Action Plans and ICCTM Sustainability

For ongoing sustainability of the ICCTM Project, CRHD recommends establishing processes and procedures to embed the following components into SCBH's system of care:

1. Community engagement
2. CLAS Standards
3. Quality improvement

Based on CRHD's expertise, listed below are sustainability recommendations for SCBH's consideration.

Document the Process: All of the QI Action Plans described in the previous pages began with community engagement and many of them established successful processes to continue to engage with community throughout the plan's development.

A documented process provides an outline of the steps taken to engage with community and serves as a resource for staff to return for future quality improvement efforts.

By creating a documented process, you improve processes moving forward, it serves as a resource for staff, preserves organizational knowledge and provides consistency to the work.

For a simple outline of the steps to create a documented process, go to creately.com.

Monitor and Review Plans: Build in an annual review cycle for the QI Action Plans to determine if an update, adaptation, or expansion is needed. The process allows each plans' vision to continue to be developed over time.

For example, the ISeeU Training QI Action Plan envisions having annual trainings on topics identified by staff. The documented process and cycles of review can accommodate the needs of this plan by including a staff engagement survey that allows staff to identify the preferred training topics for the year. Additionally, applying this review cycle to policies, procedures and documented processes allows for continuous improvement and upholds the CLAS Standards.

Engage the Community: A critical component of the ICCTM Project is ongoing community engagement. Building out community engagement opportunities for community members and partners increases buy-in by listening to and incorporating various perspectives.

CRHD recommends continuing community engagement practices, including key informant interviews, surveys and focus groups, and community forums.

These opportunities allow participants to identify barriers and potential solutions.

Some QI Action Plans may convene community partners to review the content for possible updates, edits, or recommended expansion. For other plans, engagement may require prioritizing the future staff training topics, support groups, and/or outreach efforts. Plans like the LGBTQ+ Ethnic Visibility signage campaign and TRUEcare Roadmap convened or gathered data from community partners to review drafts and provide input on the materials.

Utilize CLAS Standards: In further support of the implementation of CLAS Standards, CRHD recommends SCBH continue to complete an annual CLAS Organizational Assessment to identify accomplishments as well as areas for improvement throughout the development of the Plans.

CRHD also recommends tracking and trending the efforts of both SCBH and contracted CBOs that submit Cultural Responsivity Plans. This effort would also support the quality improvement work to identify and report out on success and opportunities for the system of care.

Establish Policies and Procedures: To sustain the impact of the ICCTM Project, CRHD recommends SCBH continue to incorporate the new "Cultural and Linguistic Considerations" section into all new and renewed policies. This will allow CLAS Standards to permeate every level of the organization.

A great example of this is the SCBH requirement that CBOs must now submit an annual Cultural Responsivity Plan. This is how long-term systemic change is built into an organization.

Community Engagement and Implementation Best Practices: Literature Review

CRHD compiled a literature review to serve as a resource, validation and motivation for ongoing systemic change. The highlighted articles include lessons for organizations working to sustain work using community engagement and the CLAS Standards.

Cultural adaptions and implementation science are discussed in the articles *A Two-way Street: Bridging Implementation Science and Cultural Adaptations of Mental Health treatments* and *Cultural Adaptation of a Scalable World Health Organization E-Mental Health Program for Overseas Filipino Workers*.

To develop effective culturally appropriate treatments these articles highlight the importance of using cultural adaptions on a project to cater approaches based on the communities being served. This includes working in collaboration with the communities of focus to confirm that the approaches are appropriate and relatable for the health topic being addressed, and that the approach is not offensive to community members.

Other articles emphasize the critical role of community engagement in prioritizing changes that will be long-term and sustainable. By listening to community concerns it enables stakeholders to come together around a shared vision and project outcomes, and ultimately accountability.

Bringing in communities at the beginning of a project is an important way for organizations to demonstrate their willingness to listen and partner with community, and to be respectful of their cultural and linguistic needs.

The Practical Playbook further emphasizes how integral community partnerships and collaborations are to create long-term sustained change with a whole person approach including equity and social determinants of health.

Of note is the best practice article that highlights the Government Alliance on Race and Equity (GARE) training that SCBH brought to their system of care during the ICCTM Project.

Valuable lessons learned are shared in other articles. One large-scale community project shared how identifying tensions that may exist between organizations and community is a valuable lesson to use moving forward; specifically understanding strategic plans of organizations and agencies collaborating on a joint effort.

In terms of funding, the Health Improvement Initiative is an example of a project that found success sustaining the work once funding ran out; seven of the nine partnerships continue to sustain the work today.

The implementation of the CLAS Standards is a common best practice that appeared through several articles to adapt service delivery to meet cultural and linguistic needs of underserved and diverse populations.

One article highlights a San Diego community clinic's effort to institutionalize the CLAS Standards through a community-based education and awareness campaign sharing lessons learned from the seven plus years of their program. Another article outlines one health care system's approach to verify competence of staff that serve as interpreters and translators for their organization. Culturally considerate approaches to Latino treatment is the focus of the article *Considerations for Culturally Competent Cognitive-Behavioral Therapy for Depression with Hispanic Patients* focuses on Latino core values and the importance of understanding of these values when treating Latino patients.

Addressing health disparities through cultural and linguistic humility trainings is the focus of another article. It outlines the impact of a providers' knowledge of racial and health disparities, in avoiding further disparities due to cultural and racial differences.

A summary matrix of the articles outlined above which includes the title, a summary, references and a PDF is available on the UCD ICCTM Report website. The narrative literature review provides more details and information about the articles to serve as inspiration.

Continued Funding Opportunities

One aspect of sustainability is acquiring the necessary funding to continue program implementation efforts. This project was fortunate to have dedicated funding from the Mental Health Services Act throughout the project's duration. To continue to implement the vision of the QI Action Plans may require additional funding. To that end, CRHD prepared a list of agencies and foundations as potential funding sources. CRHD recommends that SCBH use this list to supplement MHSA and other state and federal funding in support of the long-term vision of these QI Action Plans.

The resource below for the National Network to Eliminate Disparities in Behavioral Health provides a list of nearly 25 other foundations that complement the list of foundations and government agencies below. These are valuable resources for SCBH as well as other behavioral health agencies seeking to improve mental health outcomes in their communities:

- California Health Care Foundation
- Ford Foundation
- MacArthur Foundation National Network to Eliminate Disparities in Behavioral Health (NNED)
- National Institutes of Mental Health (NIMH)
- Robert Wood Johnson Foundation
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The California Endowment

TOOLS FOR LONG-TERM CHANGE

Tools and resources either developed by CRHD or identified as national best practices are described below to help SCBH to implement current and future QI Action Plans.

Community Needs Assessment

Annually conduct or continuously monitor community needs assessment findings, to ensure future efforts are aligned to community identified needs. A needs assessment provides information about community makeup and changes, if any additional threshold languages are emerging, and includes opportunities for potential QI Action Plans.

Listed below are a few options for conducting future community assessments:

1. Replicate the comprehensive cultural needs assessment of the ICCTM Project by using the tools provided by CRHD.
2. Use avenues that SCBH already has in place, such as the annual MHSA stakeholder engagement process, SCBH's Patient Satisfaction surveys, Workforce Equity survey, Patient Verification Survey, and the Diversity and Equity and Quality Improvement Committees to collect information to inform the community assessment.
3. Hospitals are required to complete a Community Health Needs Assessments every three years. SCBH could partner with a hospital to use that assessment for ascertaining perceived community needs and demographic changes. Listed below are Solano County hospitals along with the 2020 Solano County Community Health Assessment Report:

- NorthBay Medical Center and NorthBay VacaValley Hospital
- Kaiser Permanente Vacaville Medical Center
- Sutter Medical Center
- 2020 Solano County Collaborative Needs Assessment

Cultural Humility Trainings

During Phase 2 of the ICCTM Project, CRHD developed and conducted Cultural Competency (CC) trainings for SCBH: Cultural Competency 101, Cultural Competency 102, and Train-the-Trainer.

During this period of the project, SCBH established a training workgroup that drew inspiration from the CC 101 training to create the Diversity and Social Justice Training to highlight SCBH's strategies to address inequities.

In the same vein and taking a slightly different approach to the CC 102 training, SCBH has plans to create cultural humility trainings highlighting core values of communities of focus that are historically underserved within Solano County.

Quality Improvement Action Plan Development

CRHD recommends that SCBH continue using the ICCTM to develop future QI Action Plans with stakeholder engagement.

SCBH can use the *Quality Improvement Action Plan Template* to help stakeholder groups articulate their goals and vision to address local community needs as they develop future QI Action Plans.

The template includes prompts to outline goals, baseline assessment, stakeholders, resources and logistics, challenges, and timeline making it easy for CBOs and community members to focus on what to put in the plan rather than how to develop one.

SCBH could bring together a workgroup made up of people from different professional, cultural, and linguistic backgrounds, including consumers, their families, and community members to develop future QI Improvement Plans as shown in **Figure 8.3**.

This future workgroup could discuss community-identified barriers and proposed solutions (needs assessment findings) and put forth ideas for future QI Action Plans. SCBH and the workgroup could develop one to three QI Action Plans annually or biannually, depending on the scope of the plans put forth.

FIGURE 8.3
QUALITY IMPROVEMENT PLAN DEVELOPMENT

Coaching Template

As each QI Action Plans was developed, team members were linked to a SCBH leader that served as a coach and mentor. On a monthly basis, the coach helped the team to work through questions, concerns, and barriers encountered as they developed the plan.

The coaching template available online, provides a place for the coach and team members to document discussions, next steps for the plan and the responsible party. This template could be used to support the development of future QI Action Plans.

Quality Improvement Plan Transition Template

Once a QI Action Plans has been developed, CRHD recommends completing the Quality Improvement Transition Template to document the specific steps and key points for implementing the plan. This template is based on the information provided in the Transition Report to serve as a resource guide during implementation.

Cultural Responsivity Plan Templates and CLAS Standard Summaries

During the final implementation phase of the ICCTM Project, SCBH began requiring contracted CBOs to submit an annual Cultural Responsivity Plan. Each agency submits a plan that outlines their efforts towards fulfilling the 15 CLAS Standards. Once received, SCBH reviews each plan and provides insights and feedback to the submitting agency. CRHD developed a review process, that includes templates and CLAS Standards summaries in support of providing feedback to the agency.

The four templates listed below were developed to support an agency in meeting their CLAS goals and to track their progress towards fulfilling their goals each year.

1. Cultural Responsivity Plan Feedback Overview
2. CLAS Standard Checklist
3. Summary of CLAS Standards (charts)
4. CLAS Standard Blueprint Summaries

As additional rounds of contracts are renewed with this new contract language, SCBH may refer back to these templates and resources to support reviewing the plans and providing feedback to agencies.

CLAS Organizational Assessment and Standardized Report Template

Over the past two years, CRHD administered a CLAS Organizational Assessment for SCBH and

contracted CBOs. This assessment has been a useful tool to identify areas of accomplishment and opportunities for growth around the CLAS Standards. Participating CBOs used this information for developing their Cultural Responsivity Plans (see previous section above).

This CLAS Organizational Assessment included a version for leadership and another version to collect staff input. Upon completion, CRHD analyzed the data and provided a customized report with each agency's overall findings, and detailed explanations for each of the CLAS Standards.

During the second year of administering this assessment, the question reflection period was changed from 6-months to 1-year, to better align the report timeline with annual reporting deliverables for the organizations. CRHD recommends continue to use this 1-year reflection period moving forward.

In addition, contracted CBO's could continue to use this assessment to identify successes and challenges for embedding CLAS Standards into their organization. Included in the appendices are the two surveys and reports templates for this purpose.

Access and Health Outcomes Data Collection, Management, and Analysis

The ICCTM Project evaluation team collaborated with SCBH to undertake analyses of quantitative data relevant to ascertaining the impact of the project on access and utilization of services for the three communities of focus.

These analyses provide a preliminary roadmap for extracting relevant data, creating data sets and conducting the analyses that take advantage of the rich data embedded in SCBH's electronic health record.

Reports by CRHD include summaries of several useful quality, access, and utilization measures for the pre-ICCTM and ICCTM periods. The procedures for computing these metrics are available and can now be reported at regular intervals to monitor progress initiated during the ICCTM Project.

Decision makers may want to use these analyses to strategically manage the direction of ICCTM-related change. This also permits continuous monitoring of impact on health outcomes among the three communities of focus and will help identify additional communities that would benefit from ICCTM.

REFLECTIONS BY SOLANO COUNTY LEADERSHIP

As a capstone to this multi-year multi-agency project, during April and May of 2021, CRHD staff interviewed five leaders from SCBH and Solano County Health and Social Services. Interviews were conducted via Zoom, due to COVID-19, and interviewees answered questions about project strengths, opportunities, challenges, threats and sustainability. These conversations not only elicited important data from an evaluation standpoint, they also serve as a thoughtful summary to the ICCTM Project.

Strengths and Opportunities

Leaders identified a number of strengths from the ICCTM Project such as the community partnerships and relationships with CBOs representing diverse communities. Most significantly was the increased collaboration between county agencies and the community organizations. It is important to note that one leader identified greater collaboration as a result of the project, while another shared that the partnerships and relationships were already strong.

At the onset of the ICCTM Project, a comprehensive cultural needs' assessment was conducted where community-identified barriers and

proposed solutions were documented. In the past, SCBH leaders stated how community needs assessments by various community partners were made. By using enhanced community engagement tools and techniques, working alongside the community when making decisions that impact and effect community, one leader identified how this project moved SCBH from listening to acting through the development and implementation of the QI Action Plans.

Community forums that were well attended and encouraged community input was another high point for one leader. Another leader shared that at the height of the racial justice protests and a related local tragedy in Vallejo during 2020, SCBH embraced the community forum platform to co-host a community forum with the City of Vallejo to provide a space to process the trauma experienced by many people.

Most of the leaders identified the CLAS Standards as a valuable

addition to SCBH. One leader credited the CLAS Standards as being a focal point for SCBH's time and energy, while another leader associated the CLAS Standards with an organizational and personal cultural shift. Another positive outcome is that CLAS Trainings created a space for SCBH staff to process, discuss and strategize how to improve the mental health system of care and helped them complete projects, in spite of barriers.

Leaders felt strongly about the importance that a cultural and linguistic approach to creating and implementing QI Action Plans addressed the community identified issues. They identified that the implementation of the QI Action Plans led to increased trust and credibility within the community.

Quality Improvement Plans

The 45 school-based wellness centers were highlighted by nearly all the leaders as a great achievement from the ICCTM Project. The wellness centers are seen as a way to strengthen behavioral health presence in schools and allow for continued engagement with school districts throughout the county, and the Solano County Office of Education.

SCBH established an agreement with a Solano Community College to establish a wellness

center for staff with students. This partnership will also support creating a future career pipeline from which SCBH will be able to potentially hire.

Of the many products developed from the ICCTM Project, one leader identified outreach materials as being an accomplishment: multi-lingual resource maps, tailored backdrop and mental health prize wheel.

Leaders identified a number of policy changes that include culture and language components. Two leaders shared the example of contracted CBOs being required to submit annual Cultural Responsivity Plans, to show how their agency is striving to reduce health disparities by providing services based on the CLAS Standards.

Another noted important policy change resulting from one of the QI Action Plans is the Inclusion Statement now displayed on the SCBH website and job postings. The statement was recently referenced by an interviewee,

which the SCBH leader noted as evidence of change.

Another leader shared how the CLAS Standards are now included in any Request for Proposal; agencies submitting a proposal must indicate how their services are culturally and linguistically responsive. Additionally, one leader indicated the importance of a policy change to provide contracted CBOs with no cost access to SCBH's interpreter services contract with Language Link; making it easier for mental health consumers to receive culturally and linguistically appropriate services.

In further support of CLAS Standards, SCBH developed multiple new trainings in response to community identified concerns. Leaders highlighted the frontline reception staff training, psychiatrist training and special behavioral health interpreter trainings as additional accomplishments.

Improvements in the annual SCBH Workforce Equity Survey was identified as another accomplishment. Through the ICCTM Project, one of the QI Action Plans added survey questions pertaining to diversity, equity and inclusion into the annual survey tool. The revised survey tool has been used for the past two years and will continue to be used going forward allowing SCBH to analyze the composition of their workforce and the workforces' perspective regarding the system's implementation of CLAS Standards.

Increased confidence that Solano County was creating a cultural shift toward reducing disparities was identified as another positive outcome. As one leader noted, whichever door is used to access behavioral health services in Solano County, the expectation is that care will be individualized and responsive to the person's cultural and linguistic needs.

One leader indicated the importance of having an outside perspective from the UC Davis collaboration. Other leaders shared that increased collaboration with internal departments like Child Welfare, and external agencies such as CBOs and various California County Behavioral Health Departments was a positive outcome of the ICCTM Project.

A few leaders identified improved understanding of SCBH data and data collection as a positive outcome. During the ICCTM Project SCBH established a new practice by beginning to collect individual's sexual orientation and gender identity. Prior to this change, SCBH was unable to determine service delivery for the LGBTQ+ consumers. One leader shared that there has been an increase in the number of LGBTQ+ consumers now being served within SCBH

which is both the result of better data tracking as well as increased service utility. Finally, the data analysis, reports and products produced by UC Davis were seen as valuable resources to SCBH leaders.

SCBH and UC Davis leaders made numerous presentations to the Mental Health Services Oversight and Accountability Commission (MHSOAC) about the ICCTM Project. As a result, the MHSOAC has a proposal under consideration for a statewide ICCTM Learning Collaborative funded by the MHSOAC to provide training for all 58 Counties and two cities that receive MHSA funding.

Challenges

Given the length of the ICCTM Project, with multiple agencies and multiple components, a number of unanticipated challenges occurred. One of those challenges was staff turnover which was experienced by all the collaborators: SCBH, CBO partners, and UC Davis in particular had two Project Managers and SCBH had three Project Managers and three Ethnic Services Coordinators during the ICCTM Project as one leader pointed out.

Leaders raised a number of issues pertaining to the CLAS Training and QI Action Plans. Most significantly they shared that the ICCTM Project required more of their time and more of their staff time than they had anticipated.

One leader identified that there was not a clear understanding of how much staff time would need to be committed before the project began. Another leader felt that the CLAS Training pre-survey of 100 questions, was too long and the content was too specific about the CLAS Standards. Timelines and workload were brought up as issues, with training participants balancing their regular work responsibilities in addition to developing their QI Action Plans and attending coaching sessions.

According to one leader, some participants disengaged with the process due to frustration. Recruiting a sufficient number of committed implementers was challenging, along with not budgeting for costs associated with developing and implementing the QI Action Plans. Leaders also stated that transitioning the ten QI Action Plans to SCBH at one time was burdensome for implementation.

Another challenge could be summarized as systems issues. Although all three partner groups (CBOs, SCBH, and UCD CRHD) had similar intentions and goals to improve health outcomes, these organizations have different processes and structures that created challenges for the Project.

One leader pointed out that a county staff member was required to be involved in all the QI Action Plans, because community members do not have the ability to make changes with the county's system.

During the Project, there were changes to the electronic health record which caused challenges with data. A lack of IT personnel to access and pull data from the electronic health record system was another issue. One leader identified miscommunication as an issue due to lack of a repository to share documents between SCBH and UC Davis. One leader felt there was a disconnect between the CBO partners and SCBH, since UC Davis held the sub-contracts with CBO partners for this project.

Threats

There were a number of external threats that impacted the ICCTM Project. Though political, social, and economic systems in society will always influence a community partnership, the particular historical context of the past five years created particularly complex threats to the project.

Solano leaders noted that the ICCTM Project period included numerous external threats. The complex political landscape resulting from the 2016 presidential election threatened various aspects of the project. The worst wildfires in California history occurred during the project period. The COVID-19 pandemic spanning 2020 through 2021 required multiple adjustments to health care delivery and the ensuing economic crises, in which countless people lost their jobs and many businesses closed during the pandemic, were also noted as threats. Racial unrest sparked by the murder of George Floyd in 2020 disrupted plans, as did limited financial support for the QI Action Plans. Together, these events and circumstances presented threats to service delivery and the overall ICCTM Project.

The transition to the 45th presidential administration brought with it a number of anti-immigrant policies, including Public Charge, which created fear in immigrant communities, including Latino communities which were a key foci of this Project. The LGBTQ+ community was affected with policy efforts aimed at removing "Don't ask, don't tell," Same Sex Marriage, and healthcare access policies. People of color, LGBTQ+, and other minority groups felt particular fear for their safety during the four years of the administration.

Wildfires raged throughout the state and ravaged many parts of Solano County during the summer of 2020, causing fear, increasing stress and anxiety, and further impacting the need for, as well as the delivery of, mental health care.

For the first time in nearly 100 years, the world experienced a pandemic which brought with it, unprecedented restrictions to the way people interacted with one another. In the same time period, a racial justice movement ignited, along with a rise in Asian-Pacific Islander hate crimes as a result of the 45th presidential administration attaching a Chinese label to the Covid-19 pandemic.

SCBH leaders shared that the pandemic's physical distancing requirements isolated people from one another and changed the way people accessed care. Many students and non-essential workers began using virtual platforms from home to study and work, further isolating people from one another. In turn, behavioral health service delivery pivoted to a telehealth platform, that worked for some but not all. Due to a lack of computers or other devices to connect to telehealth services, some community members were unable to access services at a time when people needed them the most. According to one leader, this threat made it more challenging to engage and reach communities of focus.

While many of these issues were identified as threats, some leaders shared how the work never stopped being done and instead adapted to the new environment. One leader even shared how they see telehealth as an opportunity that came out COVID-19. Some of threats were identified by leaders as further validation of the value of the ICCTM Project and even more reason the work needs to continue.

Outside of the above-mentioned threats, SCBH leaders also identified budget as an issue. At the onset of the project, no funds were allocated for the implementation of the QI Action Plans. Fortunately, SCBH was able to allocate MHSA Innovation reversion funds in support of the Plans.

Finally, one leader shared how many of the threats described above impacted many of the quality improvement plans: Wellness Centers and community outreach-oriented QI Action Plans: e.g. school wellness centers and all Plans with an outreach component. Once COVID-19 gathering restrictions are lifted, SCBH intends to put the developed outreach materials into effect in support of these plans.

Sustainability

The CLAS Training was identified as a means to sustain the messaging from the ICCTM Project. Additionally, leaders identified the role of wellness centers, partnerships, monthly committee meetings, and trainings, as being critical components of sustaining the work. The 45 school-based wellness centers will continue to be supported by SCBH through a contract with the Solano County Office of Education (SCOE). In addition to the SCOE partnership, one leader identified ongoing community partnerships as another component of sustainability.

The monthly Diversity and Equity Committee meetings will provide accountability spaces to track and monitor work on the QI Action Plans from one leader's perspective. SCBH will continue to implement the plans or components of plans that have not been fully implemented.

Additionally, SCBH will continue to distribute materials developed through various QI Action Plans. In support of this, one leader shared how priority staff will continue to move quality improvement plans forward in support of long-term sustainability.

Next Steps

Two themes emerged for what comes next, maintenance and expansion.

For maintaining the ICCTM progress, stakeholder engagement is key. Leaders discussed being mindful about how engagement is done, especially when pursuing future projects. For example, they shared that there is a need to continue to develop relationships with school districts. To maintain transparency, leaders plan to create an Equity Dashboard that would allow for ongoing evaluation and maintaining the progress of the ICCTM Project.

SCBH leaders talked about the need as well as opportunities to expand the ICCTM Project. For example, most of the leaders identified the need to work with three other communities of focus as a next step: African American, Native American and Older Adults.

Other ideas for expanding the ICCTM Project included working with Solano Community College to develop a career pipeline, providing mobile crisis services supports to schools for behavioral health situations, instead of a police response; and looking at expansion of the ICCTM Project components to other counties across the state.

Lessons Learned

SCBH leaders were asked to share lessons they learned over the past five years with this Project; their responses spanned from preparation, to staff turnover, data, timeliness, strategy, and logistics.

Knowing who is committed to the project from start to finish is part of being prepared to start the ICCTM Project. They shared that participants need to understand the scope of the project and the time allocation required for success. Leaders had differing opinions about how many dedicated staff should be involved; with a range from a half-time position to multiple full-time staff.

Leaders did agree that a dedicated staff who understands the importance of focusing on community stakeholders and funding is needed. Another area of consensus was allocating a budget in support of implementing the quality improvement action plans developed into a top five list. Leaders recommended prioritizing quality improvement plans into a top five list to determine which two or three plans will initially be developed.

The remaining QI Action Plans may be folded in, to avoid working on too many plans at one time. Another recommendation is to transition the Plans to the County for implementation after each CLAS Training cohort is completed.

Leaders identified the need to understand their own data; being able to identify where the consumer utlization data comes from and how to access it to avoid unnecessary delays. Another recommendation was to take 6-months of data and run the analysis on that data to be sure it works or identify if an adjustment is needed. With staff turnover affecting every organization, including all three participating groups (SCBH, CBO partners and UC Davis), more could have been done to plan for and mitigate staff turnover. To alleviate this, leaders recommend building in mechanisms to keep the project moving forward, regardless of personnel changes.

One leader shared how the decision-making process should be aligned to community needs and that the complexity of the partnership between the three groups caused delays where, for example it took three months to decide which quality improvement topic areas to move forward.

When working with a specific community, SCBH leaders recommended that the CBO leaders clearly articulate the reason for selecting each community as a focus. This strategy proactively helps address other communities' potential concerns for not being selected. With an eye on moving the needle, another recommendation is to look at the funding already in place and select projects that easily align with those items.

Leaders agree that working with and listening to community partners is a critical component of the ICCTM Project. One leader recommended that contracts with CBO partners serving as cultural brokers should be contracted with directly by the funding agency to avoid any unintentional divisions between partnering agencies. Regarding logistics, one leader identified the importance of having routine leadership engagement to avoid bottlenecks and remove barriers to implementation. Another recommended that meetings between county project leaders and the program evaluators start near the onset of the project. Creating a shared repository for project documents for all partners to access would benefit the team being on the same page and avoid any miscommunication.

CONCLUSION

It is clear that this multi-year, multi-agency, multi-goal project was complex and challenging, and yet the ICCTM Project made a significant positive impact on Solano County and its communities.

Commitment to Community Engagement

Following best practices for community engagement, the ICCTM Project began by gathering community perspectives around barriers to accessing and utilizing mental health services, along with proposed solutions to address issues.

In partnership with the UCD CRHD, a comprehensive cultural needs assessment was conducted with input from over 200 Solano County residents and workers. Forums and meetings with community members and partners occurred throughout the duration of the ICCTM Project.

The ICCTM Project highlighted the power of working alongside community to make meaningful changes to the mental health delivery system.

Since the community needs assessment is a critical component of cultural transformation, CRHD

recommends that this step not be skipped for future iterations or adaptations of the project. If a full needs assessment is not possible, CRHD has highlighted other best practice resources to keep a pulse on changing demographics in Solano County.

Regardless of the type of assessment used, ongoing community engagement is key to putting forth meaningful plans to address community-identified concerns and solutions.

Training in Culturally and Linguistically Appropriate Services (CLAS) Standards

The CLAS Standards provide a solid foundation on which transformation can be built, beginning with a tailored CLAS training program for diverse participants.

The CLAS Standards call attention to the importance of providing culturally and linguistically oriented services and for long-term systemic change for diverse communities of focus in Solano County.

As noted in the SCBH leadership insights, this training created a space for participants to contemplate and discuss the influence and importance of culture and language on behavioral health service delivery.

Through the training, participants reframed their perspective and left with a newly acquired culture and language lens towards their work. This training also engaged participants from diverse backgrounds and supported a shift in their approach to work grounded in the CLAS Standards.

This is evidenced in the CLAS Training evaluation where participants reported that the training increased their confidence in providing appropriate mental health services, support, or resources within the communities of focus. Confidence in working with the Filipino community increased by 32 percent, the Latino community by 21 percent and 19 percent for the LGBTQ+ community.

Action Plans for Quality Improvement and Sustainable Change

The implementation of the 10 QI Action Plans, developed from the tailored CLAS Training, and based on community input are a culmination and reaffirmation of the ICCTM Project and the approach to create long-term sustained change. These 10 plans embodied the community voice from start to finish.

The ICCTM Project started with needs assessment and community input, developed plans around that input, and circled back with community throughout the project to share progress and new opportunities to provide input.

This approach to community engagement showed the community that SCBH was prepared to move beyond just listening and into action, which was further demonstrated by implementing the QI Action Plans developed from this project. At the third community forum held in April 2021, community members and participants expressed their appreciation of the work accomplished through the ICCTM Project.

During the critical time of implementation, the year 2020 brought with it a number of unanticipated, external forces identified previously in this report.

All of these events had an impact on SCBH's ability to implement all of the action plans. With Shelter-in-Place mandates on and off for over a year, QI Action Plans with a community outreach focus and trainings traditionally done in-person were placed on hold, and due to school closures the wellness centers could not be utilized.

Despite these challenges during the ICCTM Project years, SCBH has made a number of advancements that embedded CLAS Standards and community engaged research practices into their system.

Policies and procedures have been updated, for example, with content focused on culture and language that now supports the Governance, Leadership and Workforce CLAS Standards.

Program Evaluation

Since its inception, the ICCTM Project included a rigorous program evaluation that utilized the expertise of the UC Davis CRHD. The evaluation is grounded in the Quadruple Aim framework that advocates for improving consumer experience, reducing cost, advancing population health and improving the provider experience.

The evaluation design was centered on capturing the experiences of mental health consumers and providers during their interactions, examining outcomes from these interactions within a cultural and linguistic framework, and determining the cost effectiveness of the project in sustainability and replicability.

Separate reports are available with detailed program evaluation findings. Highlights of the evaluation for the Quadruple Aims are described below.

Consumer Experience

A vision of the ICCTM Project is that its activities would lead to a system that better meets the needs of consumers served by SCBH. Unfortunately, there is no data available that directly measures consumer awareness of the ICCTM Project or its impact on consumers' satisfaction with services. The evaluation team analyzed data from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.

This survey is administered twice yearly by SCBH, as required by the Department of Health Care Services (DHCS), to evaluate how the Solano County Mental Health Plan is meeting the needs of beneficiaries served. MHSIP survey results informed some of the culturally and linguistically appropriate interventions for the three focus communities, but the survey itself does not include items directly related to the ICCTM Project. Data from the MHSIP Consumer Survey show that the majority of consumers have positive experiences with SCBH services and are generally satisfied with the overall accessibility and quality of their services.

Since implementing the ICCTM Project, this high level of satisfaction has been maintained. In addition, during the ICCTM period, there have been significant increases in youth and families' report of cultural responsiveness, which suggests the program may have played a role in improving the cultural appropriateness of mental health services in Solano County.

CRHD recommends that, although distal outcomes of the ICCTM Project like service outcomes may take more time for the program to positively impact, these potential impacts should continue to be monitored.

Surveys that collect data specifically about activities of ICCTM, such as the school wellness centers. Conducting focus groups or interviews with the consumers about service outcomes may also provide more in-depth information about these findings and the role of the ICCTM Project. Conducting focus groups or interviews with the consumers about service outcomes may also provide more in-depth information about these findings and the role of ICCTM.

Provider Experience

The evaluation found that the Providing Quality Care with CLAS Training Program has the potential to improve participants' cultural responsivity and comfort with community engagement. In addition, data from the SCBH Workforce Equity Annual Survey showed that the training may also improve the experience of providers. The majority of survey respondents expressed a high level of job satisfaction (average 5.8 on a 7-point scale) and reported that they find their work meaningful (average 6.6).

Compared to those who did not participate in ICCTM Project related trainings, providers who participated reported modest (not

statistically significant) increases in confidence in working with the communities of focus and support for culturally sensitivity supervision. In addition to including items more tailored to measuring the impact of CLAS training in future surveys, CRHD recommends incorporating a qualitative approach, such as interviews or focus groups, to understand the ways the training has affected participants in their work settings and its contribution to positive job satisfaction.

Access and Health Outcomes

An analysis of data from the SCBH electronic health record showed some improvements in access and utilization of mental health services among the three communities of focus though these changes are difficult to attribute to the project due to numerous external factors.

Use of the SCBH Access Line increased during the ICCTM period and timeliness of subsequent appointments also improved. There was also a trend toward shifting the consumers' point of entry from crises services to outpatient settings during the project. CRHD recommends continuing to improve service utilization and outcomes by incorporating regular data reviews through the Equity Dashboard that is being developed to track trends as QI Action Plans are fully implemented.

Economic Evaluation

Over the 5 years of the ICCTM Project (across 6 fiscal years), SCBH contributed more than $5.7M toward its vison, implementation, and management. The impact of the program is still unfolding and the return on investment for the program should continue to be tracked.

Initial analyses indicate that the program, especially the CLAS Training and QI Action Plans, provided tangible sustainable changes, such as the school wellness centers and culturally relevant employment and supervision. Reflections of SCBH leadership, staff, and partners indicate that ICCTM Project has put in place a scaffolding for sustainable cultural change that is on the pathway envisioned and ready to share with others.

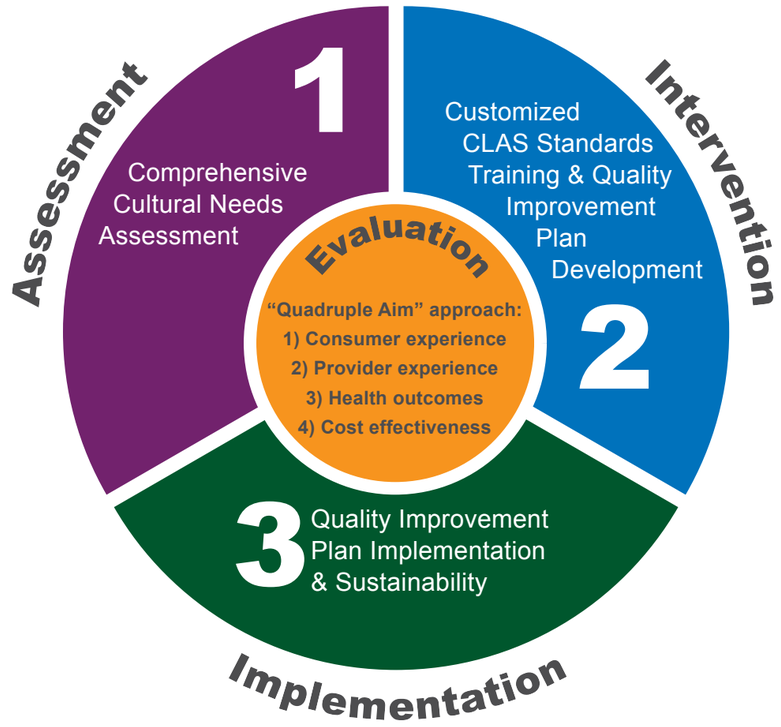
Final Thoughts

Five years ago, SCBH partnered with UC Davis CRHD to launch an ambitious multi-phase, multi-year community-initiated innovative project to improve mental health outcomes for three communities of focus following the Three Phase Plan showin in **Figure 8.4.**

Evaluations presented in the previous chapters of this report highlight the multiple positive impacts of the ICCTM Project on the three communities of focus as well as SCBH.

The potential for sustainable change in Solano County and other counties that may implement the ICCTM Project rests on several foundational elements, including a commitment to community engagement and the adoption and implementation of the CLAS Standards; CLAS Training; implementation of QI Action Plans; and a rigorous evaluation of the program.

Figure 8.4
Three Phases of the ICCTM Project



9 COMMENTS, RECOMMENDATIONS, LESSONS LEARNED BY SCBH

COMMENTS, RECOMMENDATIONS, LESSONS LEARNED, PROVIDED BY SOLANO COUNTY BEHAVIORAL HEALTH (SCBH)

This section of the report was authored by SCBH and is being incorporated into this final report by their request. The comments below, authored by SCBH staff, are provided for the benefit of similar organizations considering undertaking a program like ICCTM.

STAFFING CONSIDERATIONS

Depending on the local design, this can be an intensive and expansive project over multiple years. We found that certain staff involvement was necessary for success and continuity of the project:

- A contract manager or other staff person(s) to manage the contract and budget with UCD CRHD and the implementation of the QI Action Plans across the MHP. A full-time staff person would be ideal in order to lead the efforts and changes from within the system and routinely collaborate with the CRHD UCD team on the logistics of the project.
- A variety of staff may participate over the duration of the project such as the CLAS training series, surveys, coaching sessions, and/or action plan development and implementation. This should include all levels of the organization to include reception staff, paraprofessionals, peer providers, clinicians, supervisors and managers, as well as quality improvement staff.
- Data analytic or IT personnel who will pull service data from the electronic health record over the course of the project.
- Involvement of the Ethnic Services Manager (ESM) or team member so that efforts correspond with other cultural competence efforts and can be communicated to relevant stakeholders. While SCBH highly recommends that the ESM be closely involved with the project, overseeing this project is likely not feasible given the more expansive role and responsibilities of the ESM.
- Members of executive leadership may be necessary to sponsor some or all of the QI Action Plans.

BUDGET AND FINANCIAL PLANNING

An initial and ongoing budget and allocation of staff resources is necessary to support training cohorts, implementation and sustainability of the community-defined QI Action Plans.

Given that a number of staff will likely participate, it is important to track staff costs over the course of the project to inform the cost analysis in the final evaluation.

COMMUNITY PARTNERSHIPS & ENGAGEMENT

Community members who are cultural brokers and persons with lived experiences will be important for community engagement early in the project.

These brokers will be well positioned to participate in the CLAS Training, focus groups, and ideally longer-term during the QI Action Plan implementation. While their ongoing participation would be extremely valuable, their ongoing commitment of time may not be feasible.

IMPLEMENTATION OF QI ACTION PLANS

Prior to starting any project that will include community-defined QI Action Plans, identify the funding available to support any solutions or strategies identified through the community engagement process.

Be realistic and clear with participants about budget constraints, and whether the funding is sustainable or one-time funding, as this will inform the strategies that are developed.

Setting realistic expectations about what resources are available from the beginning of the project is vital to building and maintaining trust with the community. This may include a commitment to implement a project over time if resources are limited.

Initially 13 QI action plans were developed through three training cohorts, however through attrition and the merging of some similar plans, ten QI action plans were created and transitioned to the County for implementation simultaneously.

Managing all of QI Action Plans simultaneously was challenging for a medium-sized county with limited in infrastructure and no staff person fully dedicated to this project.

When identifying the number of participants per cohort, consider how many QI Action Plans the system can support implementing either simultaneously or sequentially. Additionally, QI Action Plans that ultimately require involvement of additional staff or stakeholders of the MHP system may require engaging new internal and external partners as well as executive sponsors to promote implementation.

Once a cohort completes the training series and coaching sessions, if the QI Action Plans immediately move to an implementation phase with County oversight, it may be much more manageable to assure that all of the Plans get proper attention and resources.

Given it is likely that one or more QI Action Plans will need specialized technical knowledge, such as graphic design or multi-media expertise, developing a relationship with a graphic designer or other technical experts early in the project would enable those projects to move forward in a timely manner. In addition, as materials are created, include enough time to obtain feedback from representatives of the target audience.

EVALUATION

In order to monitor the effectiveness of the project, UCD CRHD conducts an extensive final evaluation. Because data collection and retrieval is often a challenge for counties, an early evaluation plan is important to review what data is available, what data elements are needed, how often staff will pull data, and what staff will validate and/or interpret the data.

Throughout the project, there may be other changes that will impact the data being reviewed; these additional factors are important to document in real time and inform the external evaluation team and the teams that are developing QI Action Plans.

Reviewing the QI Action Plans and their potential interface with other initiatives on a monthly basis would be ideal. Documented workflows and processes that provide system context would be useful for the external evaluation team, along with including these topics in monthly evaluation meetings throughout the duration of the project.

UCDAVIS HEALTH

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SOLANO COUNTY INTERDISCIPLINARY COLLABORATION AND CULTURAL TRANSFORMATION MODEL (ICCTM) INNOVATION PROJECT: FINAL EVALUATION REPORT

JUNE 2021

Infographic report prepared by Inform 2 Inspire
www.inform2inspire.com

i2i inform to inspire

Universal Mental Health Screening of Children and Youth

Project Plan Proposal

July 27, 2023

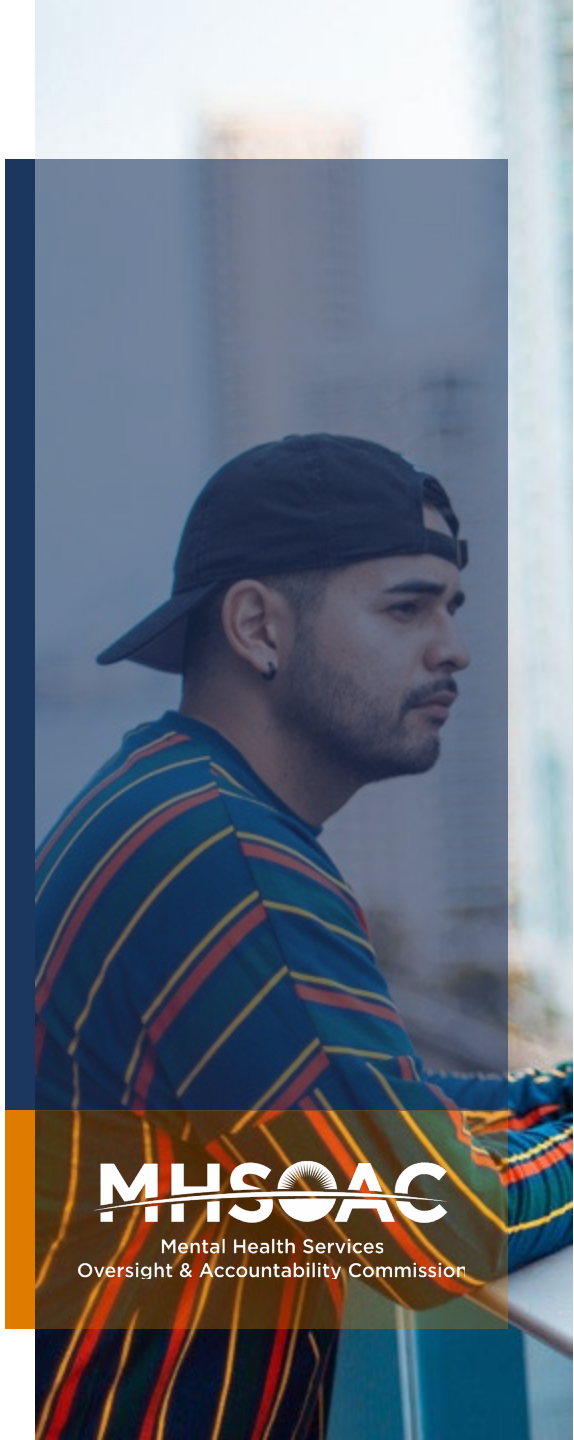
MHSOAC
Mental Health Services
Oversight & Accountability Commission

Mental health challenges among our youth

- 50% of mental health challenges begin by age 14; 75% by age 24.
- Affects 12.2% of Californians between 3 and 17 years; 30% of adolescents.
- Most are not receiving services or supports according to surveys.
- 527 young people died by suicide in 2020; half were younger than 20.

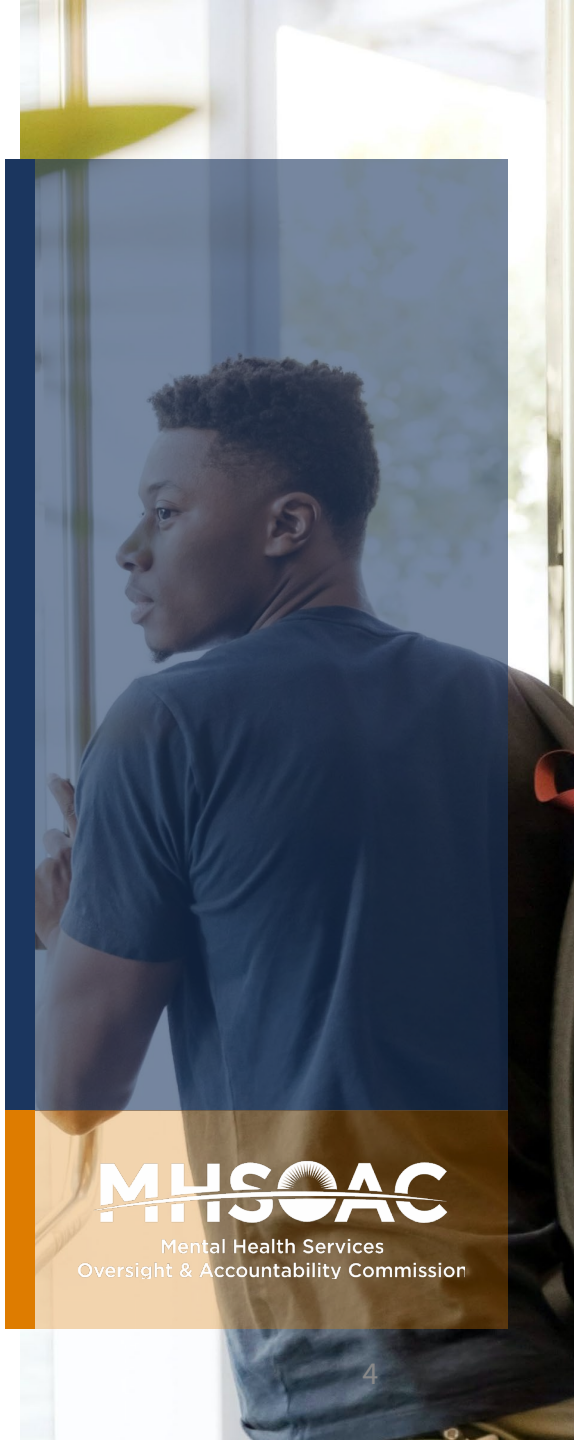
Early detection and intervention saves lives - screening is key.

- Early identification and intervention leads to better outcomes, lessens severity, and prevents suffering.
- Average delay for accessing services and support is 11 years.
- Mental health screening is critical to bridging the gap.



Universal Screening in Schools

- Schools are key setting to promote mental health.
- Universal Screening means all children and young people are assessed for risk.
- Benefits:
  1. Increases early detection and reduces unmet needs
  2. Promotes a more data-driven approach
  3. Highly cost-effective
- Tensions and barriers lead to underutilization.
- The good news… California is invested.



Universal Mental Health Screening of Children and Youth Project

The Legislature requests the Commission to report information and recommendations for expanding universal mental health screening for children and youth in California.

- Tools, best practices, barriers, and costs
- Emphasis on schools
- Used to inform future budget and policy considerations around universal screening.

Project Plan

The Commission's budget includes $**200K** to support project goals and activities.

Research and Review

- Contract with subject matter expert.

Outreach and Engagement

- Operational, travel, facilitation.

Final Report

- Material production and dissemination.

Timeline: March 2024

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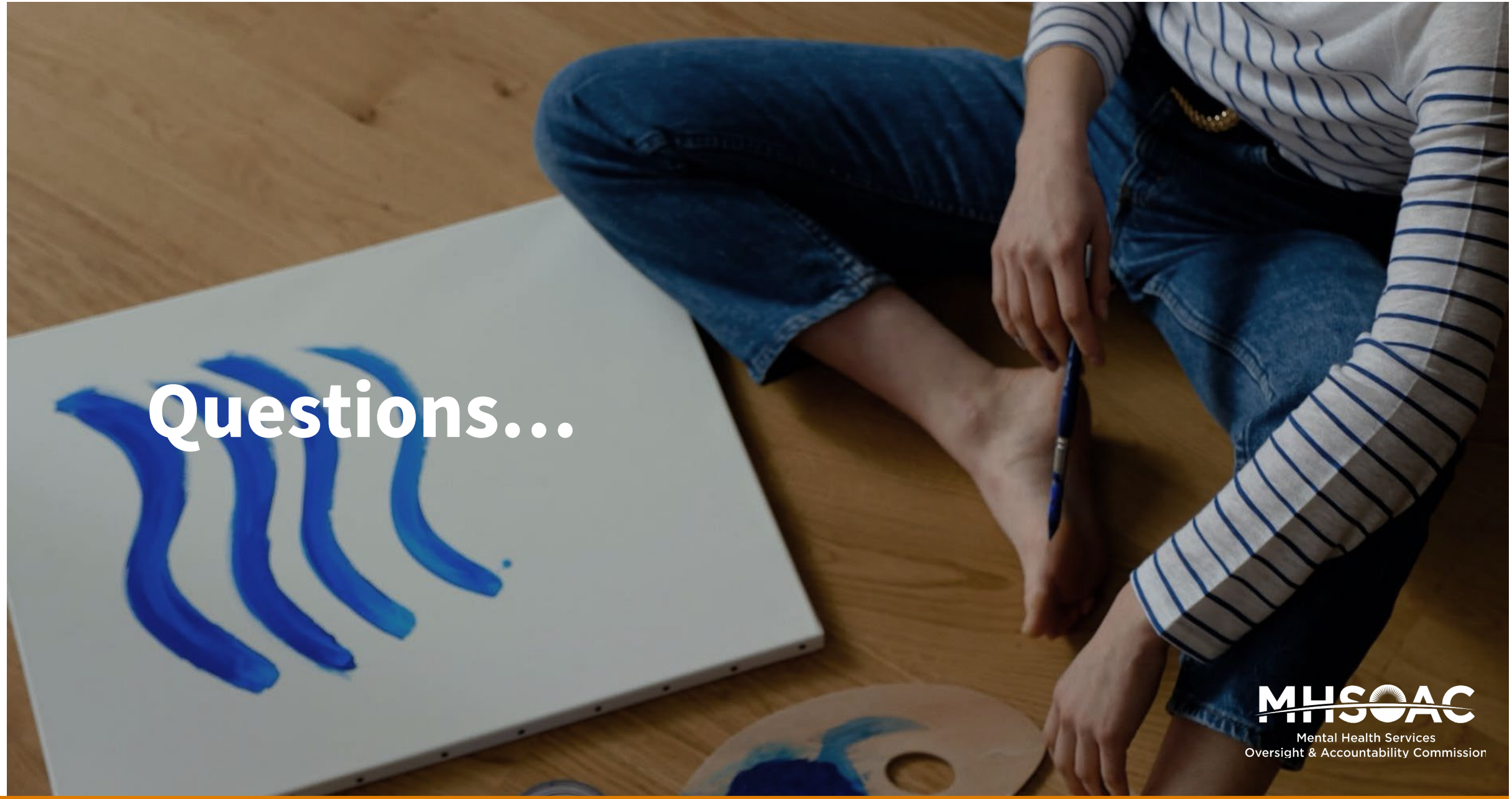
Questions...
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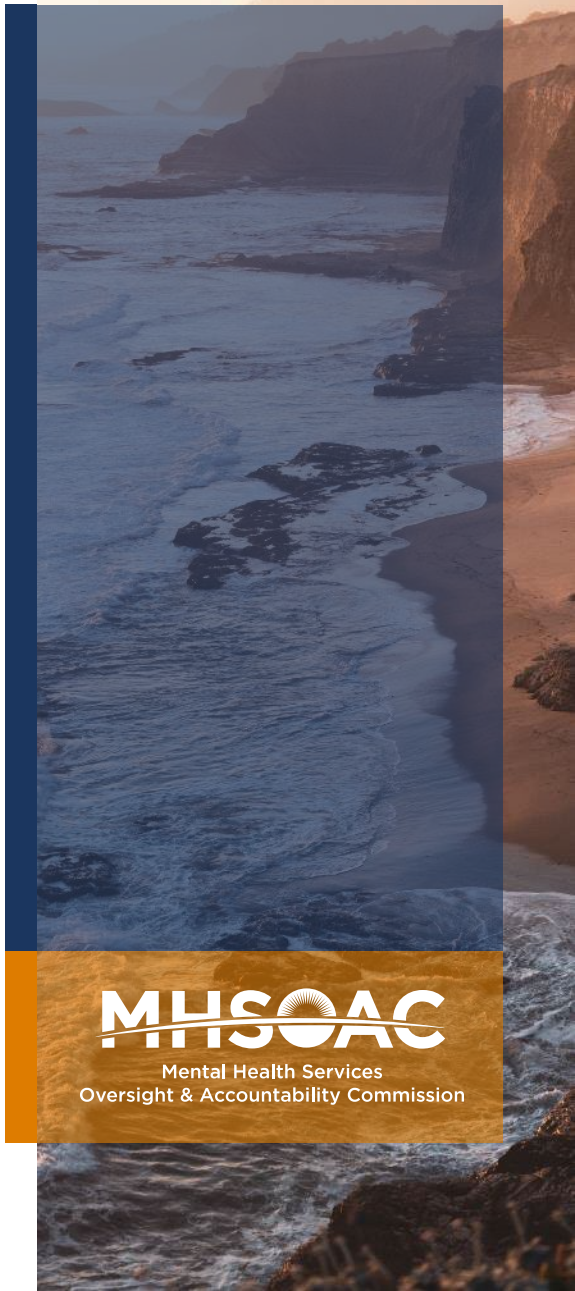
MHSOAC Budget Overview and Expenditure Plan

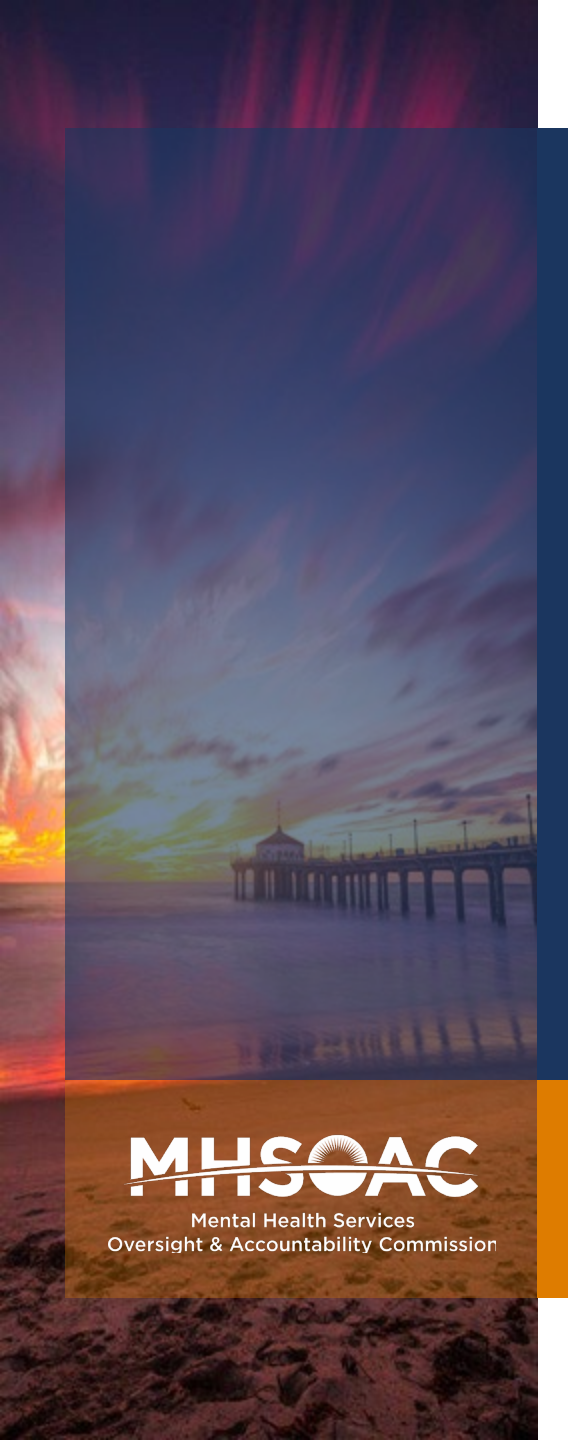
July 27, 2023

MHSOAC Expenditure Plan – 2023-24

Fiscal Year 2023-24

- July 27, 2023 – Presented for approval
- January 25, 2024 – Mid-year update
- July 25, 2024 – Fiscal Year 2023-24 Final Report

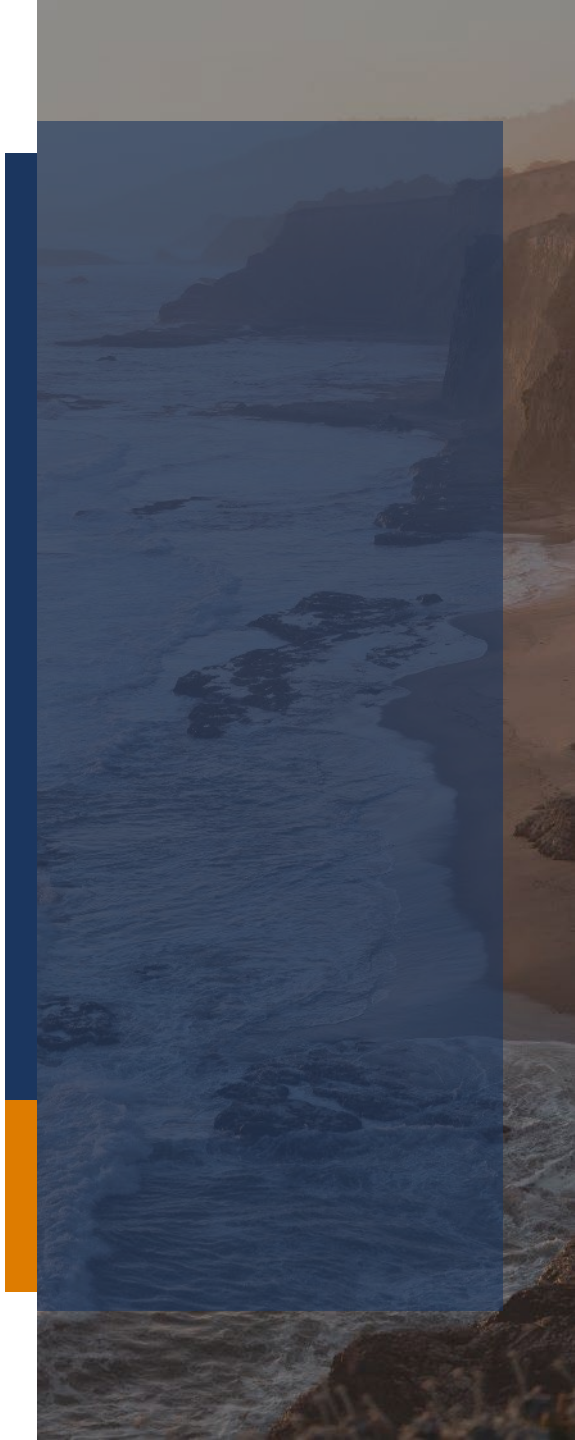




MHSOAC Budget Overview

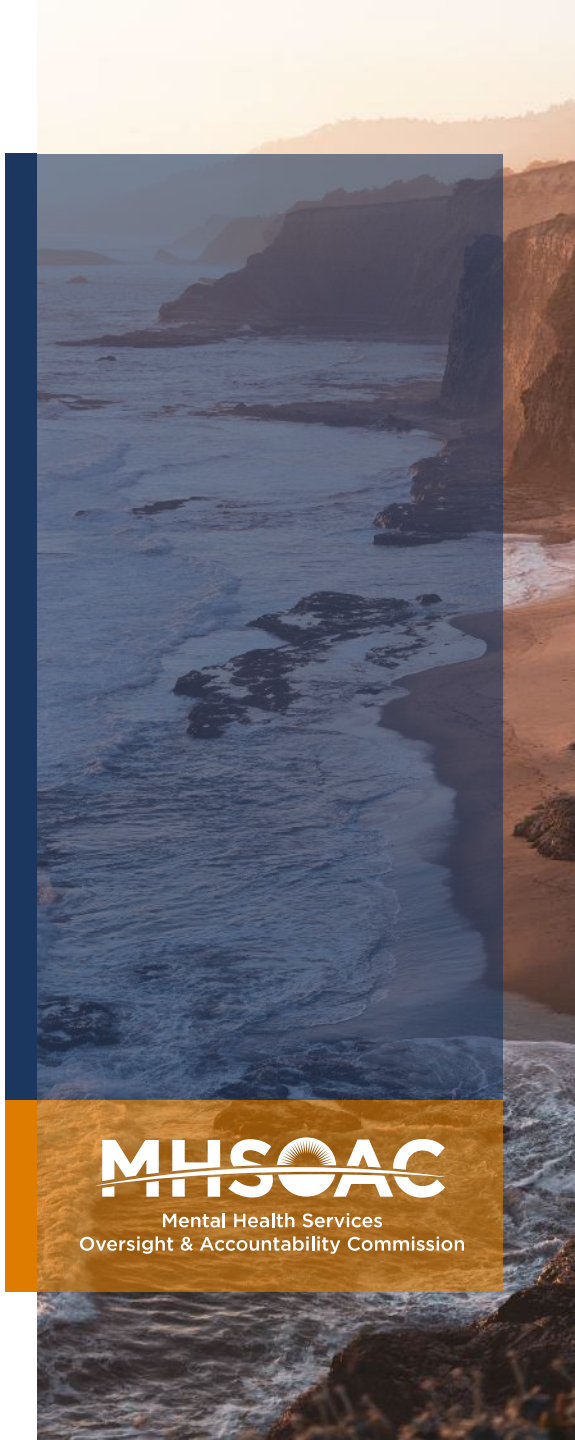
2022-23	2023-24
$111.7 Million	$64.8 Million

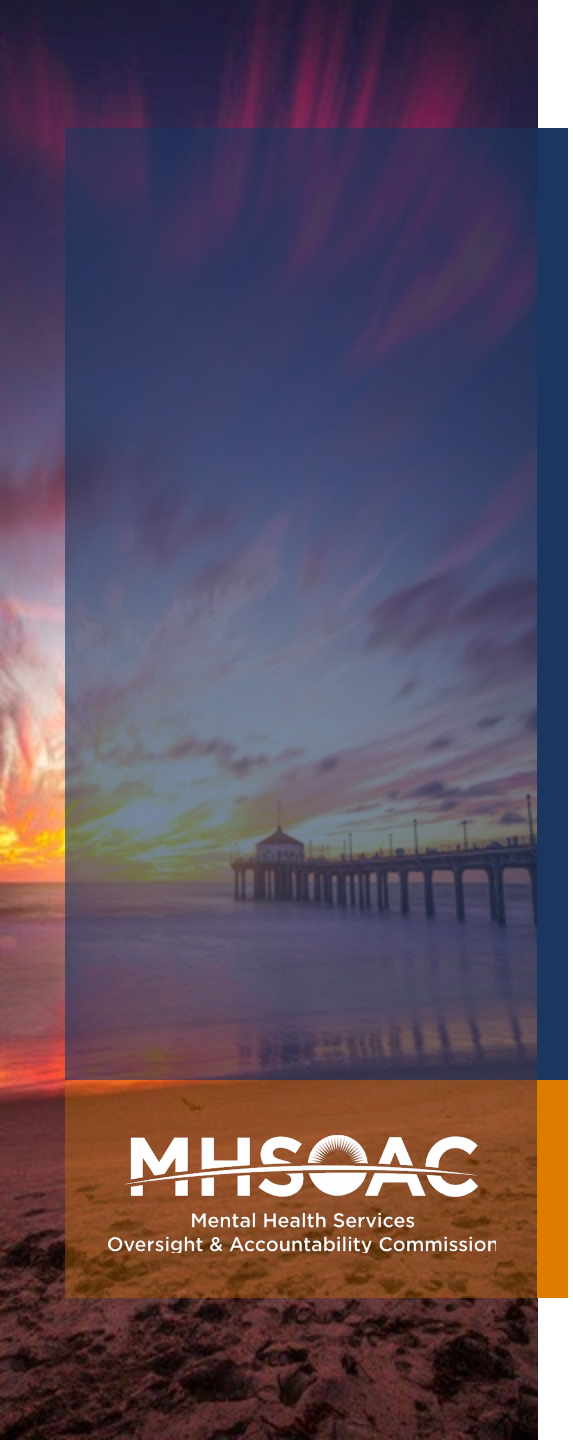
	FY 2022-23 Adjusted Budget	FY 2023-24 Budget
Operations		
Personnel	$7,380,000	$8,968,000
Core Operations	$1,784,552	$1,869,913
Commission Priorities		
Communications	$887,448	$599,418
Innovation	$100,000	$500,000
Research	$1,116,000	$1,075,669
Budget Directed		
Universal Mental Health Screening Study		$200,000
Evaluation of FSP Outcomes (SB 465)	$400,000	$400,000
EPI Reappropriation		$1,675,000
Children and Youth Behavioral Health Initiative	$42,900,000	$15,000,000
CA Behavioral Health Outcomes Fellowship	$5,000,000	
MHSSA Eval/Admin	$16,646,000	
Local Assistance		
Mental Health Wellness Act	$20,000,000	$20,000,000
Mental Health Student Services Act	$8,830,000	$7,606,000
Community Advocacy	$6,700,000	$6,700,000
Held for Reserve	-$250,000	$250,000
TOTAL	**$111,744,000**	**$64,844,000**



Budget Highlights

- Children and Youth Behavioral Health Initiative – Up to $150 Million for Rounds 4 and 5 plus $15 Million for TA.
- Universal Mental Health Screening of Children and Youth Study - $200,000
- Mental Health Wellness Act – Up to $40 Million to provide grants to programs for SUD, Maternal Mental Health/0-5, or Peer Respite.



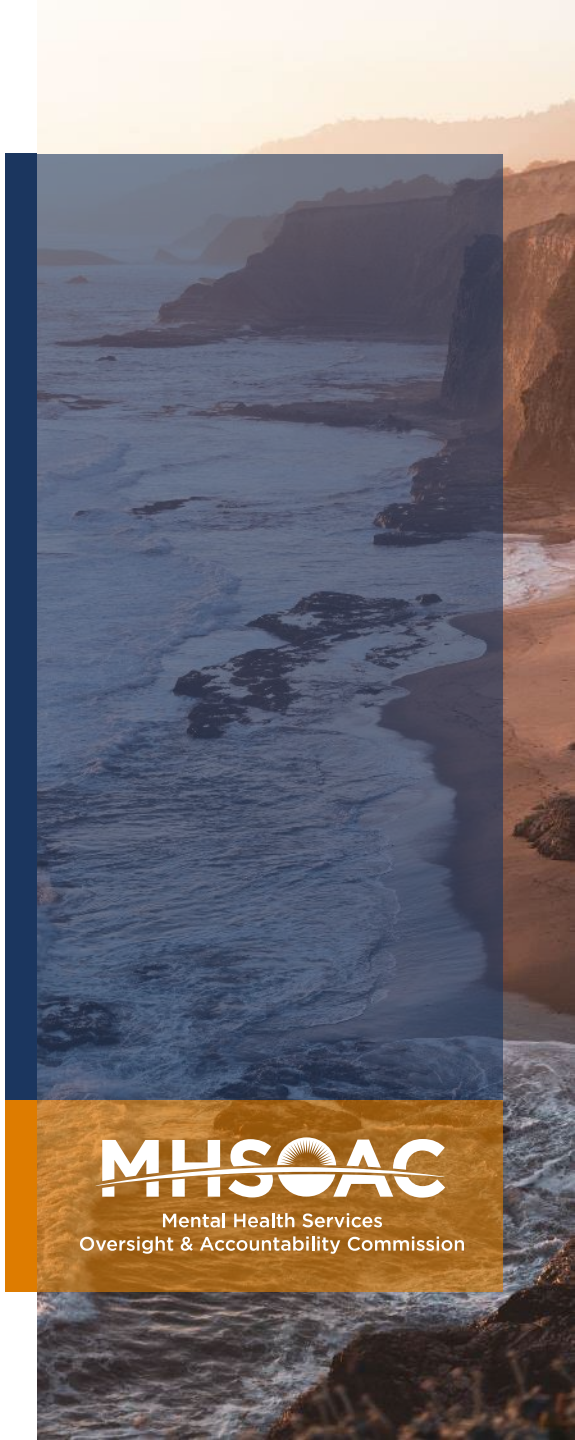


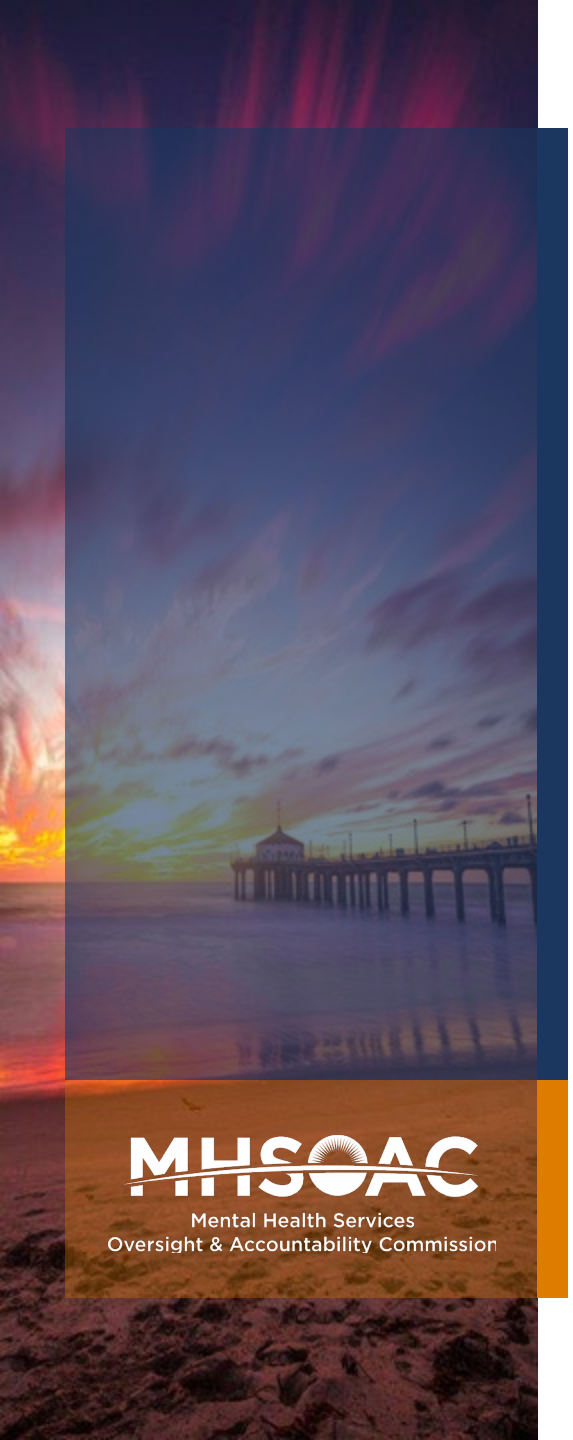
Expenditure Authorization

- Award $16.8 million to next 5 top scoring EmPATH applicants and additional funds to the TA contract to support them.
  - $16,497,727 from past Triage Reappropriations and $360,000 remaining from last year's EmPATH procurement.
- $20,000 funding to support 1 additional grant proposal for K-12 Advocacy.
- $40,000 to support Tuolumne County's innovation youth engagement efforts.
- Contract with Stanford University for up to $5 million to provide TA to CYBHI grantees.
- Contract with UC Davis for up to $5 million to provide TA to CYBHI grantees.
- Direct staff to expend up to $5 million for staff and external consultants to TA and support to CYBHI grantees.

FY 2023-24 Procurements

- Children and Youth Behavioral Health Initiative Round 4 $50 million – July 2023
- Children and Youth Behavioral Health Initiative Round 5 up to $100 million – August 2023
- Community Advocacy : Clients/Consumers, Diverse Communities, Families, LGTBQIA+, Parents/Caregivers, Veterans – October 2023
- Mental Health Wellness Act Round 3 – November 2023
- Mental Health Student Services Act – January 2024
- Mental Health Wellness Act Round 4 – March 2024
- K-12 Advocacy – April 2024





Motion

- The Commission approves the Fiscal Year 2023-24 expenditure plan and associated contracts.


Thank You
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Rolling Commission Meeting Calendar (Tentative)

At its January meeting the Commission identified four priorities: Data/Metrics, Full-Service Partnerships, the Impact of Firearm Violence, and Strategic Planning. The draft calendar below reflects efforts to align the Commission meeting schedule with those priorities. **All topics and locations subject to change**.

Dates	Locations	Priority*
July 27	Sacramento	Strategic Planning-Community Engagement Framework Governor's MHSA Modernization Proposal
August 24	Sacramento	Data Discussion
September 28	Sacramento	Strategic Planning
October 25-26	Bay Area	**10/25**-UCSF Neuropsychiatry Site Visit **10/26**-Impact of Firearm Violence Panel Strategic Planning
November 16	TBD	Strategic Plan- DRAFT
December	(no meeting)	
January 25, 2024	Santa Barbara	2024-2027 Strategic Plan Adoption Impact of Firearm Violence Report-DRAFT
February 21-22	Napa	**2/21**-State Hospital Site Visit **2/22**-IST Presentation and Panel
March 28	Sacramento	MHSA Reform-Impact on 24-27 Strategic Plan
April 25	Rural-TBD	Data Discussion
May 23	Sacramento	SUD Strategy (Panel and Presentations)
June	(no meeting)	

*NOTE: The Priorities listed are not the only agenda items under consideration for each month.