WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
October 27, 2022
9:00 AM – 1:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

OCTOBER 27, 2022

NOTICE IS HEREBY GIVEN that the Commission will conduct a Regular Meeting on **October 27, 2022, at 9:00 a.m.** This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123 and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

Date: October 27, 2022

Time: 9:00 AM – 1:00 PM

Location: 1812 9th Street, Sacramento, CA 95811

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
John Boyd, Psy.D.
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Steve Carnevale
Wendy Carrillo, *Assemblymember*
Rayshell Chambers
Shuo Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
Alfred Rowlett
Khatera Tamplen

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/82332717816
Meeting ID: 823 3271 7816

FOR PHONE DIAL IN
Dial-in Number: 408 638 0968
Meeting ID: 823 3271 7816

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the information contained after the Commission Meeting Agenda for a detailed explanation of how to participate in public comment and for additional meeting locations.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

- Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.
- Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.
- Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Commission Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

9:00 AM

1. **Call to Order & Roll Call**

   Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

9:05 AM

2. **Announcements & Committee Updates**

   Chair Mara Madrigal-Weiss will make announcements and the Commission will receive committee updates.

9:20 AM

3. **General Public Comment** *Information*

   General Public Comment is reserved for items not listed on the agenda. No discussion or action by the Commission will take place.

9:50 AM

4. **September 22, 2022 Meeting Minutes** *Action*

   The Commission will consider approval of the minutes from the September 22, 2022 Commission Meeting.

   - Public Comment
   - Vote

10:00 AM

5. **Election of the 2023 MHSOAC Chair and Vice-Chair** *Action*

   Nominations for Chair and Vice-Chair for 2023 will be entertained and the Commission will vote on the nominations and elect the next Chair and Vice-Chair; *led by Geoff Margolis, Chief Counsel.*

   - Public Comment
   - Vote

10:30 AM

6. Semi-Statewide Enterprise Health Record (EHR) Multi-County Innovation Project *Action*

The Commission will consider approval of innovation funding for the following counties to join CalMHSA's Semi-Statewide Enterprise Health Record Multi-County Innovation Project:

- Humboldt: $608,678
- Tulare: $6,281,021
- Sonoma: $4,420,447.54

Presented by Amie Miller, PsyD., Executive Director, California Mental Health Services Authority (CalMHSA).

- Public Comment
- Vote

11:30 AM

7. Break

The Commission may take a short break at the discretion of the Chair.

11:45 AM

8. Commission's Racial Equity Plan *Action*

The Commission will hear a presentation from staff on the Racial Equity Plan and consider approval of the plan; *presented by Anna Naify, Psy.D., Consulting Psychologist and Lauren Quintero, Chief of Administrative Services.*

- Public Comment
- Vote

12:05 PM

9. Innovation Implementation Plan *Action*

The Commission will hear a presentation from staff on the strengths and challenges that counties face in developing transformative innovation and explore concerns and opportunities; *presented by Sharmil Shah, Psy.D., Chief of Program Operations.*

- Public Comment
- Vote

1:00 PM

10. Adjournment

Our Commitment to Transparency	Our Commitment to Those with Disabilities
In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov	Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fails, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

If joining by call-in, press *9 on the phone. Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

If joining by computer, press the raise hand icon on the control bar. Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

Under newly signed AB 1261, by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

AGENDA ITEM 4

Action

October 27, 2022 Commission Meeting

Approve September 22, 2022 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the September 22, 2022 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) September 22, 2022 Meeting Minutes; (2) September 22, 2022 Motions Summary

Handouts: None.

Proposed Motion: The Commission approves the September 22, 2022 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date September 22, 2022

Time 9:00 a.m.

Location 1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair
Mark Bontrager
Sheriff Bill Brown
Keyondria Bunch, Ph.D.*
Steve Carnevale
Rayshell Chambers
Shuo Chen*
Senator Dave Cortese*
Itai Danovitch, M.D.*
David Gordon
Alfred Rowlett
Khatera Tamplen

*Participated remotely.

Members Absent:

John Boyd, Psy.D.
Assembly Member Wendy Carrillo
Gladys Mitchell

MHSOAC Meeting Staff Present:

Toby Ewing, Executive Director
Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Tom Orrock, Chief, Community Engagement and Grants Division
Sharmil Shah, Psy.D., Chief of Program Operations
Maureen Reilly, Assistant Chief Counsel
Amariani Martinez, Administrative Support
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:08 a.m. and welcomed everyone.

Chair Madrigal-Weiss reviewed a slide about how today's agenda supports the Commission's Strategic Plan goals and objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

Ms. Martinez called the roll and confirmed the presence of a quorum.

2: Announcements and Committee Updates

Commissioner Tamplen asked for a moment of silence and reflection in honor of Sally Zinman, a pioneer and trailblazer within the mental health community, who recently passed away. Commissioners and members of the public shared their memories and gratitude for Sally Zinman's work and accomplishments in the mental health field.

Chair Madrigal-Weiss gave the announcements as follows:

Announcements

- The August 2022 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on October 27th in Sacramento. Commissioners will make site visits to a full-service partnership program and a school wellness center.
- Marin County Site Visit Announcement. Commission staff and interested Commissioners will be conducting a site visit on October 11th to two Marin County High School Wellness Centers, which are funded through the Commission's Mental Health Student Services Act (MHSSA) program. The visit will include a tour of the San Rafael High School and Terra Linda High School Wellness Centers, which are located in the city of San Rafael.
    - This is the first of several site visits to MHSSA programs. In the coming months, the Commission hopes to visit the Wellness Centers in Ventura County. More information will be forthcoming.
- Beach Cities Allcove Ribbon Cutting Ceremony. The Commission issued grants to five programs that will provide health, mental health, education support, peer counseling, case management, and drug and alcohol counseling in one location. One of the

Commission's allcove youth drop-in center programs will be cutting the ribbon on their new center in October. This center is located in Los Angeles County and operated by the Beach Cities Health Care district. More information will be forthcoming.

- The 30-minute special screening and panel discussion of the recent Ken Burns documentary *Hiding in Plain Sight: Youth Mental Illness*, hosted by PBS-KVIE and community mental health partners, will be held tonight at 5:30 p.m. at the Sofia Theater in Sacramento.

Staff Changes

Chair Madrigal-Weiss asked Mr. Orrock to share recent staff changes.

Tom Orrock, Chief, Community Engagement and Grants, stated two new staff have joined the Commission since the last Commission meeting. He introduced Chuente Rhym, retired annuitant, who will be the lead for the Allcove Youth Drop-In Center Project, and Evonna Douglas McIntosh.

On behalf of the Commission, Chair Madrigal-Weiss welcomed Chuente Rhym and Evonna Douglas McIntosh to the Commission.

Committee Updates

Chair Madrigal-Weiss invited the Committee Chairs to provide updates on their activities.

Children's Committee

Chair Madrigal-Weiss stated the update for the Children's Committee is included in the meeting materials and will be posted online.

Client and Family Leadership Committee Update

Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CFLC last met on September 20th and heard an update on the CARE Courts legislation, Senate Bill (SB) 465, and discussed how peer respites and full-service partnerships could be enhanced to lessen the referral and need for court ordered treatments. The Committee also discussed aspects of the legislation which may affect mental health treatment for individuals referred to the program.
- The Committee heard an update on the Peer Certification Resource Guide and discussed next steps in the creation and distribution of the guide.
- The Committee took time to remember Sally Zinman and highlighted the values and qualities that Sally has demonstrated in her work and her life as a true champion for mental health consumers and the mental health system as a whole.
- The next CFLC meeting will take place on Tuesday, October 25th, but the date may change to Monday, October 24th, due to possible conflicting schedules.
- The Committee will also meet on Tuesday, November 15th.

Commissioner Chambers, Vice Chair of the CFLC, added that the Committee will bring recommendations to the Commission on other strategies that prevent individuals from going into involuntary care, such as peer respites, emergency psychiatric units, crisis residential centers, and more funding for community-based organizations.

Cultural and Linguistic Competency Committee Update

Vice Chair Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CLCC last met on September 8th and heard from one of the Commission's advocacy contractors, the California Pan-Ethnic Health Network (CPEHN), on their A Right to Heal Project for Years 1 and 2, ongoing efforts, accomplishments, themes and findings from the 2021 and 2022 statewide reports on mental health in diverse communities, and outlook for Year 3.
- CPEHN's virtual A Right to Heal event, a gathering of community members from Black, Indigenous, and communities of color to talk about mental health and wellness, will be held on September 20th with powerful testimonies from community members and partners who took part in the 2022 report.
- The next CLCC meeting will take place on Tuesday, October 18th.

Impact of Firearm Violence Subcommittee Update

Chair Madrigal-Weiss stated the Commission formed a subcommittee at the last Commission meeting to explore opportunities to address the mental health impacts of firearm violence, wherein she appointed Commissioner Bunch as the Chair. She appointed Commissioner Brown as Vice Chair of the Subcommittee.

Prevention and Early Intervention Subcommittee Update

Chair Madrigal-Weiss stated the update for the Prevention and Early Intervention (PEI) Subcommittee is included in the meeting materials and will be posted online.

Research and Evaluation Committee Update

Commissioner Danovitch, Chair of the Research and Evaluation Committee, provided a brief update of the work of the Committee since the last Commission meeting:

- MHSSA Evaluation: The Committee is working with community engagement and the grants team on a unified community engagement strategy to inform the evaluation and technical assistance components of the MHSSA.
    - The team sent out a Request for Qualifications (RFQ) to prospective external evaluators for the MHSSA evaluation and has received six responses. Over the next few weeks, those responses will be reviewed, scored, and narrowed down. The Research and Evaluation Committee MHSSA Workgroup will be asked to review and weigh in on the selection process for those evaluators.

- The purpose of the MHSSA Workgroup is to provide guidance to staff and the Commission on evaluation of the MHSSA. The first meeting of the MHSSA Workgroup will be convening on Wednesday, October 5th, from 1:30 p.m. to 3:00 p.m.

- Triage Evaluation: There is ongoing data collection and analysis for the summative evaluation of triage.
- Full-Service Partnership (FSP) Program Evaluation: In preparation for a November 15th report to the Legislature of FSP programs that the Commission supports, Research and Evaluation Division staff are working on a writeup, which will be shared at the October Commission meeting.
- Data and Infrastructure: Research and Evaluation staff has been refining several of the dashboards within the Transparency Suite for accessibility and clarity of the information.
- The Data Warehouse Team has received data from the California Department of Education, Employment Development Department, and Vital Statistics and has been working on linkages to the client services information data that will allow answers to specific evaluative questions, such as school attendance and increase in youth who receive mental health services through school-based mental health.
- The next Research and Evaluation Committee meeting will be held at the beginning of next year.

3: <u>General Public Comment</u>

Mary Ann Bernard, retired lawyer, family member, and advocate for the severely mentally ill (SMI), reminded Commissioners that the last clause of Welfare and Institutions Code Section 5840(c) mandates that prevention and early intervention shall include programs that reduce the duration of untreated severe mental illnesses and assist people in quickly regaining productive lives. The speaker stated relapse prevention for consumers who are already severely mentally ill is mandatory for PEI and is included in existing regulations for that reason.

Mary Ann Bernard was sad to see that the August draft of the PEI document, which defines relapse prevention as tertiary prevention at page 17, skips it entirely in the priorities that follow. There is only one confusing and misleading mention of it at page 59, which states that the Wellness Act funds crisis PEI but fails to mention that MHSA both funds and mandates these services. This section needs to be refocused on PEI for existing illnesses or it is pointless to include it in the document.

Mary Ann Bernard stated, most importantly, one year ago, the California courts ordered and the Legislature has since been scrambling to create diversion and reentry programs for SMIs who have for years been warehoused and treated horribly in jails and prisons. MHSA has also contained another completely ignored mandate. It is not supposed to be a choice. Section

5813.5(f) says that the MHSA shall include services similar to the Mentally Ill Offender Crime Reduction Grant Program, but recently clarified that the Legislature is to include services for presentencing or post-sentencing programs, parole, probation, post-release, or mandatory supervision.

Mary Ann Bernard stated the Commission is trying to use money efficiently, which is a good thing. Crisis intervention centers and jails are where the revolving-door consumers who desperately need relapse prevention services are. Significant MHSA PEI money should be focused on relapse services. If the Commission focuses money on those services, it will save lives and avoid human misery for SMIs, their loved ones, and those that they harm, which why so many of them end up in jail to begin with although they do not belong there. The MHSA mandates this; it has always mandated it.

Steve Leoni, consumer and advocate, shared memories and gratitude for Sally Zinman's work and accomplishments in the mental health field.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated she invited everyone at the last meeting to a special convening in Los Angeles on Friday, October 14th, called Culture is Health 2022, which will involve all participating organizations of the California Reducing Disparities Project (CRDP). The purpose of this convening will be to share the preliminary results of the statewide evaluation. Every Commissioner will be receiving a personal invitation from Dr. Rohan Radhakrishna, Deputy Director and Chief Equity Officer at the Department of Public Health.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, ACCESS California, a program of Cal Voices, stated concern on behalf of families on the Central Coast with dual diagnosis mental health who struggle with accessing mental health services for their children and adult children in the community.

Richard Gallo stated the CARE Court bill is not intended to be used with MHSA funding. The speaker stated the need for the Commission to review the intent of MHSA funding.

Miya Bray, Graduate Student, University of Alabama at Birmingham, and Intern, REMHDCO, asked for a review of the PEI Subcommittee Draft Report regarding SB 1004 to be put on the agenda for the next CLCC meeting on October 18th.

Steve Dilley, Executive Director, The Veterans Art Project (VETART), invited Commissioners to attend the VETART Capital Event from 10:00 a.m. to 4:00 p.m. on October 12th.

Zauna Nuru-Bates, Statewide Advocacy Liaison, ACCESS California, a program of Cal Voices, introduced themself and stated they looked forward to the rest of this meeting and attending future Commission meetings.

April Breis, Advocacy Director, ACCESS California, a program of Cal Voices, introduced themself and stated they are excited to see the work going on and to be a part of it.

Mark Karmatz, consumer and advocate, shared memories and gratitude for Sally Zinman's work and accomplishments in the mental health field. The speaker also asked for additional details on the CRDP event on October 14th.

4: August 25, 2022, Meeting Minutes (Action)

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the August 25, 2022, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

Public Comment. There was public comment.

Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Tamplen made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves the August 25, 2022, teleconference Meeting Minutes as written.*

The Motion passed 11 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chambers, Chen, Cortese, Danovitch, Gordon, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioner Brown and Rowlett.

ACTION

5: Early Psychosis Programs (Action)

Presenters:

- Sharmil Shah, Chief, Program Operations
- Tom Orrock, Chief, Community Engagement and Grants
- Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs

Chair Madrigal-Weiss stated the Commission will hear an update on the multi-county Early Psychosis Learning Health Care Network Innovation Project, will hear an update on the Early Psychosis Intervention Grant Program, will receive information about the successes and challenges of implementing a Coordinated Specialty Care Clinic model, and, will consider approval of an Early Psychosis Intervention Plus Grant Program Award.

Commissioner Bunch recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Madrigal-Weiss invited the presenters for this agenda item to come to the presentation table.

Sharmil Shah, Chief, Program Operations, provided an overview, with a slide presentation, of the background, areas of focus, participating counties, and goals of Assembly Bill (AB) 1315, which established the Early Psychosis Intervention Plus (EPI-Plus) Program.

Mr. Orrock continued the slide presentation and discussed Commission action to expand the EPI-Plus Program. He stated Santa Barbara County has elected to not pursue the early psychosis program at this time, due to critical staffing shortages. He provided two options for allocation of the returned funds: augment returned funds with retained funding and award $2 million to the next highest scoring applicant from the initial EPI Plus procurement; or release a new Request for Applications (RFA) and award funds to the most qualified applicant.

Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, provided an overview, with a slide presentation, of the challenge, goals, evaluation components, timeline, progress to date, Beehive data collection, county data analysis update, fidelity assessment update, challenges and successes, and vision of EPI-CAL, California's Statewide Early Psychosis Learning Health Care Network and Training and Technical Assistance (TTA) Center. She noted that this early psychosis template can be used for other projects and issues such as trauma and eating disorders.

Commissioner Comments & Questions

Commissioner Carnevale asked if there is a mechanism in place to address workforce issues via consistency of best practices and training across the UCs and CSUs to try to take a system view.

Dr. Niendam stated this needs to be explored. Creating that infrastructure by ensuring that the future workforce is being taught these evidence-based practices is important. Currently, the workforce is coming out of UCs and CSUs without that foundational knowledge. She gave the example that cognitive behavioral therapy often must be retaught because many people have never been exposed to it or they have incorrect views of it. She noted that these skills must be retaught before anything can be layered on related to psychosis but, once those skills are taught, psychosis, trauma, anxiety disorders, and depression can be layered on.

Commissioner Carnevale suggested thinking more about that. Workforce development issues pervade much of the work of the Commission. A systemic approach is important. What is being done with early psychosis programs can impact all mental health. The only thing that is missing is that programs deal with symptoms but do not change the trajectory.

Commissioner Carnevale stated the need to begin thinking about root cause research understanding and not just about managing symptoms after they have gotten out of control. This research provides the ability to look at root causes. Although early onset psychosis is the most difficult to study, it possibly has the biggest window of understanding of what creates these problems and how to begin to intervene early to reduce future problems.

Dr. Niendam stated the research in the last couple of years has expanded the understanding of the numbers. Incidence rates looking across commercial insurance and Medi-Cal show that California should expect 27,000 new cases of psychosis per year. In Sacramento County alone,

that means 1,000 individuals – this program is set up for one-tenth of that. Clinical high-risk individuals are expected to reach 100,000 individuals who need services per year. These are individuals who are not in school, who do not graduate, and who struggle to get a job; their first contact with mental health is through law enforcement, and they end up on the streets.

Commissioner Carnevale stated this will cost the system of fortune on top of the human tragedy.

Dr. Niendam agreed and stated it will cost $45,000 per person per year.

Commissioner Carnevale stated the need for early intervention is massive.

Dr. Niendam noted that trauma and systemic racism are also causal factors in psychosis. These issues are also important to address.

Commissioner Chambers highlighted the workforce issue of burnout. She stated Painted Brain trains aspiring clinicians. She suggested that innovation in this area focus on training early on in evidence-based practices and how, as a system, to create whole and healthy environments for clinicians who are on the frontline addressing psychosis, one of the most complex mental health challenges.

Dr. Niendam stated One Mind has been partnering with UC Davis to develop an approach to addressing workforce burnout and to better understand what is driving it, which is different across staffing levels.

Commissioner Chambers stated the importance of ensuring that peers are in leadership roles, that lived experience is as valued as the other multi-disciplinary team members' expertise, that peers are not tokenized for their experience, and that the workplace is set up for individuals of all disabilities, including individuals with psychiatric disabilities.

Commissioner Rowlett stated the UC Davis Early Psychosis Program visited his organizations many times. He stated appreciation for the emphasis on the Social Determinants of Health inculcated throughout the presentation and the reference to systemic racism and how it impacts individuals along their journey. He stated the need for a data platform that is shared across all participants. That part of the work will provide a template for how behavioral health services should be delivered in other areas.

Vice Chair Alvarez also stated appreciation for the emphasis on the Social Determinants of Health but also for the connection in integrating community-defined practices to better serve the needs of the community. This chips away at systemic racism. She asked how streamlining data collection interacts or connects with electronic medical records (EMR).

Dr. Niendam stated one of the challenges of connecting to an EMR is the high level of security involved and the multiple EMRs throughout California, even within each county. The application must build a back-end into all of those EMRs. She noted the importance of learning what providers want to see in an EMR. EMRs are not built for clients or family members to review. Services must be billable so UC Davis built the EMRs so they can be reviewed in real-time with the individuals being served. There are challenges in the goals of

how to build the EMRs, because they are designed for different things, and then how to integrate them.

Dr. Niendam stated the long-term vision is to be able to sit with a client without onscreen distractions, but that is not how they are designed. She noted that providers may have up to five EMRs onscreen, depending on the client in the room. This leads to them feeling burnt out and uncomfortable, and ultimately leaving their jobs. It does not feel like it is made for them. This is part of the qualitative work being done with community partners – trying to understand their needs and their goals for the data and how to build something to meet those needs, while also understanding the needs of the payers for the state and how those needs can be met.

Chair Madrigal-Weiss agreed with the statewide approach, leadership team, and community-defined practices. The community knows their needs, but more work needs to be done on the system side to bring that forth. It is important to have a system with common definitions in the mental health system in order to identify, track, and create measurements.

Commissioner Bontrager stated the Early Diagnosis and Preventative Treatment Clinic (EDAPT) Program is a prime example of how a robust set of services that are well-resourced can actually move the needle, which is a novel idea in a mental health field. The EDAPT Program provides more services that are better and faster, and it makes a difference. The idea of proof-of-concept matters because this can be applied in several other areas of mental health.

Commissioner Bontrager asked if there has been a discussion about the inclusion of the UC Davis group in the e-consult component of the new $1 billion statewide virtual platform.

Dr. Niendam stated this has been discussed as a way to build up service. The hub-and-spoke approach was created as one way of providing service to someone who is not local. Another way of doing that is through e-consult. The UC Davis team has discussed being able to do that to provide direct clinical service. One of the challenges is that the assessments are thorough and take approximately four hours to complete to help understand what is driving an individual's symptoms. Counties have said that they can set up the peer, case manager, clinician, and prescriber; however, the assessment lift is so heavy that they ask UC Davis to provide that component. The assessment is a direct billable service, not just a consult. All of these different things need to be considered to meet local need, depending on the resources available.

<u>Presentation, continued</u>

Chair Madrigal-Weiss asked Mr. Orrock to present the options available to allocate available funds for the Early Psychosis Grant Program.

Mr. Orrock stated Santa Barbara County has elected to not pursue the early psychosis program at this time, due to critical staffing shortages. He provided two options for allocation of the returned funds:

A. (Recommended) Augment returned funds with retained funding and award $2 million to the next highest scoring applicant from the initial EPI Plus procurement.

B. Release a new RFA and award funds to the most qualified applicant.

Commissioner Comments & Questions

Commissioner Chambers asked if there were other counties interested in joining that did not apply.

Mr. Orrock stated the first RFA had five applicants and the second had eight. Two grants were awarded; one subsequently dropped out.

Dr. Niendam stated many other counties will receive support from the Department of Health Care Services (DHCS) contract.

Executive Director Ewing clarified that Option A would quickly award the remaining funds to the next candidate in line. Option B would require a new procurement that will take six to nine months but would allow counties to apply that chose not to apply initially or that wanted to revise their proposal to perhaps score higher. He stated Dr. Niendam is pointing out that there are multiple sources of funding that counties can use to participate in this project.

Commissioner Brown stated, given the limited amount of funding available, that the initial applicants were told that remaining funds would be available for them, and that it would take six to nine months for a new procurement process, he moved approval of the staff recommendation.

Commissioner Danovitch seconded.

Commissioner Rowlett asked about the provision in the initial RFA that provided, if there were funds that were returned or not utilized, that other applicants might be considered; or, that awarded applicants might receive additional dollars.

Mr. Orrock stated the initial RFA stated funds would go to the next highest-scoring applicant who did not receive funds.

Vice Chair Alvarez stated it is troubling that Santa Barbara County backed out due to staffing shortages. She stated the purpose of e-consult is to leverage resources from across the state and across the country to bring in assistance where there are critical staffing shortages. She asked staff to learn more about Santa Barbara County's critical staffing shortages and where there may be opportunities to provide assistance.

Mr. Orrock stated it may have been due to staffing shortages across the system. The sense was that there were not only shortages in clinical staff but also in administration and behavioral health leadership.

Commissioner Brown agreed that that was the case. The county has the same concerns with its co-response programs and with specialized programs that call for nontraditional

approaches or scheduling. It is difficult to find qualified individuals to take these positions. He stated, although it pains him to see the funding leave Santa Barbara County, the most expeditious route to get it working would be to get it back out there as quickly as possible.

Public Comment

Anna stated medical model language is being used even though this project talks about recovery and trying to involve community and individuals who will receive these services. She suggested using the term consumer-driven rather than client- and consumer-centered services. She stated she did not hear that consumers, peers, peer support specialists, and advocates were a part of designing this program. She urged UC Davis to include individuals at the table when creating these programs. She also urged UC Davis to adhere to the principle of "nothing about us without us."

Theresa Comstock, Executive Director, California Association of Local Behavioral Health Boards & Commissions (CALBHB/C), and Chair of the State Rehabilitation Council that advises the California Department of Rehabilitation (DOR), emphasized the importance of integrating vocational services with mental health services for individuals experiencing early psychosis. Employment is a major therapeutic tool. The DOR provides education and employment services to individuals with disabilities. Some mental health agencies offer integrated vocational services for youth and adults, but the speaker stated it would be good for all communities to offer vocational services as a key component in early psychosis programs. This is an essential piece.

Mark Karmatz suggested reviewing the Fidelity Assessment Common Ingredients Tool (FACIT), developed by Dr. Jean Campbell out of the University of Missouri and University of Illinois.

Kerry Ahearn, CEO, Aldea, agreed that there is a workforce crisis. Nonprofit providers would like greater access to funding.

Julie Burns, Chief Program Officer, Aldea, complimented the work of UC Davis. Not only are they leading cutting-edge advances in early psychosis, but they are credible, ethical, and responsible with the available resources. In terms of statewide leadership and the collaborative, working proactively with a prevention- and education-minded approach works. The speaker stated the need to sustain the individuals and organizations that are devoted to this work.

Commissioner Discussion

Commissioner Tamplen referred to Anna's comment about "nothing about us without us," and asked Dr. Niendam to provide additional details about peer-run organizations that are working in the community, especially public mental health communities involved with this program.

Dr. Niendam stated one of things found in trying to engage local communities is some of them do not have much of a psychosis focus. This is an important piece of the voice to be amplified. One of the ways UC Davis is investing the funding is to create a group of advisors

who are paid for their time at a good wage to help create more opportunities for individuals with lived experience with psychosis to be a part of the process. UC Davis will be reaching out again to peer-run organizations to find individuals who would like to join this group, and working to create a family support person advisory group as well.

Commissioner Tamplen asked if communities of color will be prioritized.

Dr. Niendam stated they will. It is important to center those voices and those needs in all the work being done. Having representation from all diverse communities in California is challenging. UC Davis is working with communities to help identify individuals who will help to bring forward community concerns.

Commissioners Tamplen and Chambers offered to help in the recruitment process.

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

- *The Commission awards a contract of $2 million to the next highest scoring applicant from the EPI Plus RFA_002 Grant Program.*

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

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Carnevale, Danovitch, Gordon, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Chambers.

Commissioner Bunch rejoined the meeting.

6: <u>Mental Health Wellness Legislative Update</u> (Action)

Presenters:

- Toby Ewing, Executive Director

Chair Madrigal-Weiss stated the Commission will hear an update on recent adjustments made to the Mental Health Wellness Act (SB 82), consider approving funding for the emPATH emergency psychiatry program, and provide guidance on the priorities for future funding opportunities. She asked staff to present this agenda item.

Toby Ewing, Executive Director, provided an overview of the background, concerns, and modifications made to the SB 82 Triage Grant Program. The Commission receives $20 million annually to support the SB 82 Triage Grant Program. Those funds were not allocated last year, since staff was working to improve the efficacy of these limited funds by securing greater flexibility in how they could be used. The Legislature and Governor authorized staff's recommended changes during the 2022-23 budget process.

Executive Director Ewing stated the Commission identified three priorities for the next round of SB 82 funding: strategies to reduce unnecessary emergency department utilization and hospitalizations, opportunities to support services for children ages zero to five, and programs to meet the needs of older adults.

Executive Director Ewing stated a presentation was given at the July Commission meeting from Scott Zeller, M.D. on emPATH Units as a solution for emergency department psychiatric patient boarding of patients with acute mental health issues, which addressed the first of the three priorities for SB 82 funds identified by the Commission. The Commission expressed interest in supporting expansion of this strategy. Staff has put together a proposal for providing SB 82 funding through a competitive grant program to support the expansion of emPATH units.

Commissioner Comments & Questions

Commissioner Tamplen asked for additional details about the proposed funding to expand the emPATH units.

Executive Director Ewing stated the proposal is for $20 million for three to five years, for a total of $80 million, but the current fiscal arrangement would require modification depending on how the balance of those funds are used.

Commissioner Tamplen stated the need to ensure that other strategies such as peer respites will also be funded.

Vice Chair Alvarez asked how the funding over the next few years will be discussed as a Commission.

Executive Director Ewing stated a presentation was given at the October Commission meeting from Jackie Wong from First 5 California on targeting SB 82 Triage Grants for the zero-to-five age group, the second priority for SB 82 funds identified by the Commission, to help build infrastructure for families and to create systems that are trauma-informed and healing-centered. He stated, if the Commission would like to invest SB 82 funding in the zero-to-five population, staff can identify a certain project to invest in.

Executive Director Ewing stated, on the older adults priority for SB 82 funding, staff attempted to arrange a presentation from the then-director of the Department of Aging, who was transitioning to the Governor's office. Staff met with the new director of the Department of Aging, Susan DeMarois, and participated in a statewide conference earlier this week around the State's master plan on aging. The master plan includes strengthening the capacity to address the behavioral health needs of older Californians as part of the effort to support Californians of all ages. Simultaneously, staff would like to enhance the capacity to understand what the greatest needs are and what is effective in the older adult community. Ms. DeMarois has offered to work with staff to develop a proposal for the Commission's approval on the needs of older adults.

Executive Director Ewing stated this is an opportunity to talk about priorities and to give staff direction. If the Commission chooses to approve $20 million to the emPATH model, there would be $60 million remaining for investment.

Commissioner Danovitch stated the importance of finding opportunities to address substance use disorders, which impact all populations. He addressed the emPATH piece. There is a dramatic similarity between the emPATH model and the early psychosis program

presented today in that these are empirically supported models of care that address critical issues among individuals at risk for serious mental health problems. EmPATH Units are a form of secondary prevention because it is taking something that has already become a problem and trying to prevent it from becoming worse. It also links to the Commission's goal to reduce unnecessary emergency department utilization and hospitalizations and to facilitate appropriate and effective treatment in the community.

Commissioner Danovitch made a motion to approve the staff recommendation.

Commissioner Carnevale seconded.

Vice Chair Alvarez suggested exploring how to leverage historic investments made by the state in children and youth behavioral health, both community schools for K-12 and the $4 billion Children and Youth Behavioral Health Initiative. She stated one exciting aspect is the shift in one-on-one care to more dyadic care approaches, which consider the parent and child as a unit when it comes to taking care of families. The DHCS has moved forward in paying for dyadic care approaches, particularly in mental health. This is an opportunity that more providers are beginning to pick up and wanting to explore, even though it is a new space. She encouraged the Commission to explore this new delivery of care that is more responsive to culture and family settings, is more inclusive, and can start to change the delivery of care for many communities.

Commissioner Tamplen urged the inclusion of peer respites in the SB 82 funding.

Commissioner Rowlett stated he would abstain since he did not feel he had enough background on the emPATH model to provide an informed vote.

Commissioner Gordon stated the importance of providing services to families with very young children to increase the chances of reducing health disparities.

Chair Madrigal-Weiss agreed with Commissioner Danovitch on the need to include specific programming around substance use disorders. She asked staff to work with Commissioners to bring back a proposal on access to addiction services, the zero-to-five population, peer respite, and older adults.

Public Comment

Angela Vasquez, Policy Director over Mental Health, Children's Partnership, lifted up the Commission's discussion around investing some of this funding in infant and early childhood mental health programming. The Children's Partnership would support expanding investment specifically in classroom-based models of infant and early childhood mental health consultation, where a clinician provides ongoing support to a childcare provider rather than temporary support for a child in distress. These programs show incredible promise for reducing disparities in preschool suspensions and expulsions, particularly for Black children, and also support socio-emotional development of all children in the classroom.

Angela Vasquez stated these preventive mental health interventions are not readily available through the traditional health care system for many reasons, a large one being that there is

not an identifiable client or patient with a medical need. These are the types of culturally responsive and early intervention supports, however, that marginalized children and youth require. The Children's Partnership asked the Commission consider dedicating some portion of these funds for infant and early childhood mental health programming, including consultation within early learning and care settings.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, asked, with the large number of Afghan and Ukrainian refugees coming into California now, many of whom have children, how this program will help those who are at risk or already have PTSD and other diagnoses such as depression, which are associated with experiences of trauma and conflict in warzones.

Chair Madrigal-Weiss asked staff to contact Dr. Benhamida offline to answer her question.

Commissioner Discussion

Commissioner Bontrager asked, when talking about structural inequities, whether there will be some allowance through this program specifically where rural counties can participate due to issues of scale and resources.

Executive Director Ewing stated, as outlined in the meeting materials, it is recommended that at least one of these programs be dedicated to children. He suggested including in this proposal that there be a set-aside or designation in the procurement with additional points for rural counties. If the Commission so directs, equity can be built into the design that recognizes the greater challenges in rural counties to access this kind of care.

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

- *The Commission approves the proposed outline for a Request for Application, directs staff to issue such RFA for the allocation of $17 million of Mental Health Wellness Act funding to increase the number of emPATH emergency psychiatry ICU programs, authorizes staff to enter into contracts with the highest scoring applicants, and approves $3 million of Mental Health Wellness Act funding for technical assistance and evaluation utilizing a sole-source process, which is in the public interest because of the nature and urgency of the program and its alignment with the goals of Welfare and Institutions Code Section 5848.5.*

The Motion passed 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Danovitch, Gordon, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Rowlett.

7: <u>Break</u>

Due to time constraints, no break was taken.

8: <u>Behavioral Health Fellowship Funding Proposal</u> (Action)

Presenters:

- Toby Ewing, Executive Director

Chair Madrigal-Weiss stated the Commission received a $5 million budget allocation in 2022-2023. Staff will provide an overview of the Fellowship Project and be presented with options on how best to allocate the $5 million for the Behavioral Health Fellowship project. She asked staff to present this agenda item.

Executive Director Ewing provided an overview of the background, goals, and implementation plan of the Behavioral Health Outcomes Fellowship for Transformational Change. He stated these funds will be scaled to provide more funding up front to allow for planning and development with declining revenues over time so that the partner will be able to move this fellowship to be self-sustaining through tuition, fees, donations, and grants. This seed funding will launch a long-term strategy to ensure that the public sector behavioral health workforce has access to the education, training, and support modeled after the language of the MHSA with emphasis on outcomes, performance, recovery, and disparities.

Commissioner Comments & Questions

Commissioner Gordon asked if the lead proposer would need to be an academic institution or if they can be a nonprofit organization or other institution interested in workforce development. Several foundations run significant training programs.

Executive Director Ewing stated the benefit of connecting with an academic institution is that they would have a history in the public administration field; however, the lead will be determined by the partners.

Commissioner Chambers agreed with Commissioner Gordon that foundations and particularly community-based organizations, are on the ground, see the challenges, and can inform research-to-practice and practice-to-research. She stated she hoped to see a partnership that does not only include academic providers.

Public Comment

Stacie Hiramoto stated the need for the RFA to be developed in conjunction, transparency, and collaboration with individuals from the public or the CLCC, if this has to do with reducing disparities. She provided the example of a recent RFA for a project involving suicide prevention that was put out in a way that did not implement the intent of the legislative funds from the sponsor, which was the Asian Pacific Islander Legislative Caucus. She asked for more transparency and collaboration during the RFA process to ensure that it will reduce disparities and target individuals from underserved communities.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to approve the proposed Outline for an RFQ, to direct staff to issue such RFQ, and to award $5 million from the Mental Health Services Fund

to establish a Behavioral Health Outcomes Fellowship to the most qualified applicant. Commissioner Gordon made a motion, seconded by Commissioner Bunch, that:

- *The Commission approves the proposed Outline for a Request for Qualifications, directs staff to issue such RFQ, and to award $5 million from the Mental Health Services Fund to establish a Behavioral Health Outcomes Fellowship to the most qualified applicant.*

The Motion passed 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Danovitch, Gordon, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

9: <u>Transition Age Youth (TAY) Advocacy Outline</u> (Action)

Presenters:

- Tom Orrock, Chief, Community Engagement and Grants

Chair Madrigal-Weiss stated the Commission will consider approval of the Request for Proposals (RFP) outline for advocacy, education, and outreach on behalf of TAY. She asked staff to present this agenda item.

Mr. Orrock provided an overview, with a slide presentation, of the background of advocacy contracts, TAY advocacy contract history, community engagement findings, RFP outline, minimum qualifications, and next steps in the TAY advocacy contracting process.

Commissioner Comments & Questions

Geoff Margolis, Chief Counsel, asked to add "in the amount of $670,000 per year for three years" to the end of the proposed motion.

Vice Chair Alvarez applauded staff for meaningfully engaging the community, gathering valuable public input in the development of this RFP, and reflecting those changes in the RFP.

Mr. Orrock stated staff also heard from TAY during the listening sessions and focus group that young people want to be involved in the mental health process, implementation, and decision-making. TAY are the workforce of the future. This can be another focus of this work.

Commissioner Chambers stated the hope that the RFP will include incentives to those who employ youth.

Public Comment. There was no public comment.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to approve the proposed Outline, to direct staff to issue a Request for Proposals for the TAY Advocacy Contract, and to authorize staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants for advocacy, education, and outreach on behalf of TAY in the amount of $670,000 per year for three years. Commissioner Tamplen made a motion, seconded by Vice Chair Alvarez, that:

- *The Commission approves the proposed Outline, directs staff to issue a Request for Proposals for the TAY Advocacy Contract, and authorizes staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants for advocacy, education, and outreach on behalf of Transition Age Youth in the amount of $670,000 per year for three (3) years.*

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

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Gordon, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

ADJOURNMENT

Chair Madrigal-Weiss stated the next Commission meeting will take place on October 27th. There being no further business, the meeting was adjourned at 12:51 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
September 22, 2022

Motion #: 1

Date: September 22, 2022

Motion:

That the Commission approves the August 25, 2022 Commission Meeting Minutes

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Commissioner Carnavale

Motion carried 11 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☐	☐	☒	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☒	☐	☐	☐	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☐	☐	☒	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary

Commission Meeting
September 22, 2022

Motion #: 2

Date: September 22, 2022

Motion:

That the Commission award a contract of $2 million to the next highest scoring applicant from the EPI Plus RFA_002 Grant Program.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Danovitch

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

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☐	☐	☐	☐	☒
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☐	☐	☒	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☐	☒
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
September 22, 2022

Motion #: 3

Date: September 22, 2022

Proposed Motion:

That the Commission approves the Proposed Outline for a Request for Application, directs the Staff to issue such RFA for the allocation of $17 million of Mental Health Wellness Act funding to increase the number of emPATH emergency psychiatry ICU programs, and authorize Staff to enter into contracts with the highest scoring applicants, and approves $3 million of Mental Health Wellness Act funding for technical assistance and evaluation utilizing a sole-source process, which is in the public interest because of the nature and urgency of the program and its alignment with the goals of Welfare and Institutions Code section 5848.5.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commissioner Carnevale

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☐	☒
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☐	☐	☒	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
September 22, 2022

Motion #: 4

Date: September 22, 2022

Proposed Motion:

That the Commission approves the proposed Outline for a Request for Qualifications, directs the Staff to issue such RFQ, and to award $5 million from the Mental Health Services Fund to establish a Behavioral Health Outcomes Fellowship to the most qualified applicant.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Bunch

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☐	☒
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary

Commission Meeting
September 22, 2022

Motion #: 5

Date: September 22, 2022

Motion:

That the Commission approves the Proposed Outline, directs Staff to issue a Request for Proposals for the TAY Advocacy Contract and that the Commission authorizes Staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants for advocacy, education, and outreach on behalf of Transition Age Youth.

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Vice Chair Alvarez

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

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☐	☒
10. Commissioner Danovitch	☐	☐	☐	☐	☒
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

October 27, 2022 Commission Meeting

Election of the Chair and Vice-Chair for 2023

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2023 will be conducted at the October 27, 2022 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and begins January 2023.

This agenda item will be facilitated by Chief Counsel, Geoff Margolis.

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
October 2022

Mayra Alvarez, Los Angeles

Current MHSOAC Vice Chair

Joined the Commission: December 2017

Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization.

She also serves as a First 5 California Commissioner, appointed by Governor Newsom. Previously, she served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California, Berkeley. Commissioner Alvarez fills the seat of the Attorney General designee.

Mark Bontrager, Napa

Joined the Commission: November 2021

Mark Bontrager has been Behavioral Health Administrator for the Partnership HealthPlan of California since 2021. He was Director of Regulatory Affairs and Program Development for the Partnership HealthPlan of California from 2018 to 2021 and Executive Director of Aldea Children and Family Services from 2007 to 2018, where he was Deputy Director from 2005 to 2007. Commissioner Bontrager was an attorney in private practice from 2002 to 2006 and held multiple positions at the Villages of Indiana Inc. from 1996 to 2003, including Program Manager, Therapist and Social Worker. Commissioner Bontrager is vice chair of the Napa County Workforce Investment Board. He earned a Juris Doctor degree from the Indiana University School of Law and a Master of Social Work degree from the Indiana University School of Social Work. Commissioner Mark Bontrager fills the seat of representative of a health care service plan or insurer.

John Boyd, Psy.D, Folsom

Joined the Commission: June 2013

John Boyd is Sutter Health's Chief Executive Officer of Mental Health Services. He has an extensive background in healthcare administration and mental health. Prior to joining Sutter in 2008, he served as Assistant Administrator for Kaiser Permanente Sacramento Medical Center and has worked as both an inpatient and outpatient therapist in several organizations.

He is a Board Member of National Mental Health America; he has also served in other appointed capacities, including City of Sacramento Planning Commissioner. Boyd is a Fellow with the American College of Healthcare Executives. He earned his doctorate in psychology at California School of Professional Psychology and his MHA from USC. Commissioner Boyd represents an employer with more than 500 employees.

Sheriff Bill Brown, Lompoc

Joined the Commission: December 2010

Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006, and reelected in 2010, 2014 and 2018. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor, and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980.

Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy, the Delinquency Control Institute, the Northwest Command College, and the FBI National Executive Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles

Joined the Commission: August 2017

Keyondria Bunch, Ph.D., is Supervising Psychologist for Los Angeles County Department of Mental Health. Dr. Bunch has been with Los Angeles County since 2008 and has worked in several positions including clinical psychologist and supervisor for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Program, clinical psychologist for juvenile justice mental health quality assurance, and a clinical psychologist for Valley Coordinated Children's Services.

She has been an adjunct lecturer at Antioch University as well as worked within the mental health court system around issues of competency. Dr. Bunch is currently a supervising psychologist at West Valley Mental Health outpatient program. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles

Joined the Commission: February 2018

Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017, which encompasses East Los Angeles, Northeast Los Angeles, and the neighborhoods of El Sereno, Echo Park, Lincoln Heights, Chinatown, and parts of Silver Lake.

She is a member of the Health, Appropriations, Utilities & Energy, Labor Privacy and Consumer Protections, and Rules Committees. Assemblymember Carrillo has advocated for educational opportunities, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of the community-based radio program "Knowledge is Power" in Los Angeles.

Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived in the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Steve Carnevale, San Francisco

Joined the Commission: April 2021

Steve Carnevale is the executive chairman of Sawgrass, a developer of digital industrial inkjet technologies and cloud-based mass customization software. He runs a family-owned wine business in the Napa Valley called Blue Oak and is the founder and chair of the advisory board for the UCSF Dyslexia Center which is translating cutting edge neuroscience to enable precision learning. In addition to other education non-profit board service, Carnevale is a founder and co-chairs Breaking-Barriers-by-8, where he works with other non-profits, schools, corporations, and foundations toward achieving 100 percent literacy for all by age 8. He is also an advisor to ESO Ventures, a social venture fund in Oakland for community workforce development of unrepresented populations and is the former President and Emeritus Chair of The Olympic Club Foundation, whose mission is to support disadvantaged youth sports programs that develop future community leaders. Commissioner Carnevale represents an employer with fewer than 500 employees.

Rayshell Chambers, Los Angeles

Joined the Commission: May 2022

Rayshell Chambers has been Co-Executive Director and Chief Operations Officer at Painted Brain since 2016. She was Program Analyst III at Special Service for Groups from 2011 to 2018. Chambers held several positions at the City of Los Angeles Human Services Department and Commission on the Status of Women from 2006 to 2010, including Legislative Coordinator and Community Outreach Coordinator. She earned a Master of Public Administration degree in public policy and administration from California State University, Long Beach. Commissioner Chambers represents clients and consumers.

Shuo Chen, Berkeley

Joined the Commission: April 2021

Shuo Chen is General Partner at IOVC, an early-stage venture capital fund based in Silicon Valley focused on enterprise and SaaS, where she has invested in dozens of startups now unicorns or acquired by Fortune 50 companies. She is a Lecturer at the University of California, Berkeley, and Faculty at Singularity University, where she teaches entrepreneurship and emerging technologies. Chen is a co-author to one of the leading books on financial regulations published by Cambridge University Press. In addition to her investing and teaching roles, Chen is the CEO of Shinect, a Silicon Valley-based non-profit community of 5,000+ engineers passionate about entrepreneurship. She is also a Board Member of Decode, the largest tech and entrepreneurship community co-hosted with UC Berkeley and Stanford student organizations, alumni networks, and entrepreneurship centers, as well as an Advisory Board Member of Yale School of Medicine's Center for Digital Health and Innovation. Commissioner Chen fills the seat of a family member.

Senator Dave Cortese, Santa Clara

Joined the Commission: September 2021

California Senator Dave Cortese represents District 15 in the California State Senate which encompasses much of Santa Clara County in the heart of Silicon Valley. Along with his accomplished career as an attorney and business owner, the Senator previously served on the Santa Clara County Board of Supervisors, the San Jose City Council, and the East Side Union High School District Board. Senator Cortese was a major architect of School Linked Services, a program that connects students and families to behavioral health services and counseling in Santa Clara County. Commissioner Cortese fills the seat of a member of the Senate selected by the President pro Tempore of the Senate.

Itai Danovitch, M.D., Los Angeles

Joined the Commission: February 2016

Itai Danovitch, M.D., MBA is Chairman of the Department of Psychiatry and Behavioral Neurosciences at Cedars-Sinai Medical Center in Los Angeles since 2012, as well as Director of Addiction Psychiatry at Cedars-Sinai since 2008. His clinical practice and research focus on substance use disorders, as well as the integration of medical and mental health services.

Dr. Danovitch is a Distinguished Fellow of the American Society of Addiction Medicine, a Fellow of the American Psychiatric Association and past president of the California Society of Addiction Medicine. Dr. Danovitch earned his medical doctorate from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles Anderson School of Management. In his role as Commissioner, Dr. Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento

Joined the Commission: January 2013

David W. Gordon is the Superintendent of the Sacramento (CA) County Office of Education. He holds a B.A. from Brandeis University and an Ed.M. and Certificate of Advanced Study in Educational Administration from Harvard University.

David has dedicated his career to education with a focus on Special Education. He has served on the President's Commission on Excellence in Special Education, the Governor's Advisory Committee on Education Excellence, and a visiting scholar at Stanford University. Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego

Current MHSOAC Chair

Joined the Commission: September 2017

Mara Madrigal-Weiss is the Executive Director of Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education.

Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director.

Madrigal-Weiss received her M.A. in Human Behavior from National University, a M.Ed in School Counseling, and a M.Ed in Educational Leadership from Point Loma Nazarene University. Madrigal-Weiss has been dedicated to promoting student mental health and wellness for over 19 years. She is a past president of the International Bullying Prevention Association (IBPA) the only international association dedicated to eradicating bullying worldwide.

Madrigal-Weiss is a member of the California Department of Education's Student Mental Health Policy Workgroup. Commissioner Madrigal-Weiss fills the seat of the State Superintendent of Public Instruction designee.

Gladys Mitchell, Sacramento

Joined the Commission: January 2016

Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009.

She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993.

She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Al Rowlett, Sacramento

Joined the Commission: November 2021

Al Rowlett was named Turning Point Community Programs' Chief Executive Officer in 2014. Commissioner Rowlett has been with the agency since 1981 and today provides leadership and guidance to over 40 programs in several Northern and Central California counties. He holds a Bachelor of Arts degree from Ottawa University, a Master's in Business Administration in Health Services Management from Golden Gate University and in Social Work from California State University, Sacramento (CSUS). He is also a Licensed Clinical Social Worker.

Rowlett was appointed as a trustee to the Elk Grove Unified School District in 2009 serving through 2012. He is currently a Volunteer Clinical Professor at the University of California Davis Department of Psychiatry co-directing the Community Psychiatry seminar for residents and formerly served as an adjunct professor for the CSUS Mental Health Services Act cohort. In 2020, Assembly Speaker Anthony Rendon re-appointed Al to the California Institute for Regenerative Medicine Board. Commissioner Rowlett fills the seat of a mental health professional.

Khatera Tamplen, Pleasant Hill

Joined the Commission: June 2013

Khatera Aslami Tamplen has been the consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012.

She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007-2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002-2007, including director of rehabilitation.

Tamplen is a member of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services National Advisory Council and a founding member of the California Association of Mental Health Peer Run Organizations. Commissioner Tamplen represents clients and consumers.

AGENDA ITEM 6

Action

October 27, 2022 Commission Meeting

Semi-Statewide Enterprise Health Record Multi-County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Humboldt, Sonoma and Tulare County's request to fund the following new Innovation (INN) project:

1. **Semi-Statewide Enterprise Health Record Project (EHR Project)**

COUNTY	Total INN Funding Requested	Duration of INN Project
Humboldt	$608,678	5 Years
Sonoma	$4,420,447.54	5 Years
Tulare	$6,281,021	5 Years
TOTAL:	**$11,310,146.54**	

Humboldt, Sonoma and Tulare Counties are seeking approval to use INN funds to partner with California Mental Health Services Authority (CalMHSA) on the Semi-Statewide Enterprise Health Record Innovation Project (hereafter referred to the EHR Project) along with approximately 20 other counties. CalMHSA is a Joint Powers of Authority (JPA) formed in 2009 to create a separate public entity to provide administrative and fiscal services in support of the members' Mental/Behavioral Health Departments acting alone or in collaboration with other departments. Consistent with the five key principles identified later, this project will result in an enterprise software solution to support county business needs and EHR management, and to facilitate data sharing.

The EHR Project is designed to affect local-level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting. The overall goal to increase the quality of mental health services, including measurable outcomes and promote interagency and community collaboration. Together, these 23 counties are collectively responsible for 4,000,000 (27%) of the state's Medi-Cal beneficiaries.

Counties have prioritized this INN project in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current workforce and improve the quality of services during a time of rising need for mental health treatment services. Working with the counties, CalMHSA has identified three key aims for this project:

1. Reduce documentation burden by 30% to increase the amount of time an already scarce workforce can devote to providing treatment services.
2. Facilitate cross-county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden.

The EHR Project hypothesizes that reducing the impacts of documentation will increase provider satisfaction and employee retention, and improve patient care and outcomes. Through the identification of challenges/shortcomings within existing (legacy) EHR systems that are a key indicator of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County Behavioral Health Plans' workforce as well as the clients they serve.

The EHR Project plans to engage counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the immediate future. The key principles of the EHR Project include (see pages 4-5 of project plan for specifics):

• **Enterprise Solution**: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County Behavioral Health Plans.

• **Collective Learning and Scalable Solutions**: Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems.

• **Leveraging CalAIM**: California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment led by the Department of Health Care Services to transform and strengthen Medi-Cal. CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi- Cal claiming).

• **Lean and Human Centered**: CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety, and natively collects outcomes.

• **Interoperable:** Reimagining the clinical workflow so critical information about the people being served is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

CalMHSA has selected Streamline Healthcare Solutions, LLC as the vendor for the development, implementation, and maintenance of the EHR Project. RAND is the selected evaluation vendor and will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators.

Commission staff shared this project with its six Community Partner contractors, its listserv and both the Client and Family Leadership and Cultural and Linguistic Competence Committees on the following dates:

- May 18, 2022 (Tulare County)
- July 6, 2022 (Sonoma County)
- September 27, 2022 (Humboldt, Sonoma, Tulare Counties)
- October 12, 2022 (Humboldt, Sonoma, Tulare Counties)

Three supportive comments were received in response to Commission sharing the EHR Project plan with Community Partner contractors, the listserv and the Committees, and have been provided in the staff analysis for review.

There was one letter of opposition received and it has been included as an enclosure and was shared with CalMHSA.

Enclosures (4): (1) Commission Community Engagement Process; (2) Biography for the EHR Project Presenter; (3) Staff Analysis: EHR Project; (4) Community Partner Letter of Opposition

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

Additional Materials (1):
A link to the EHR Project INN Plan is available on the Commission website at the following URL:

https://mhsoac.ca.gov/wp-content/uploads/CalMHSA_INN_Semi-Statewide_EHR_Plan.pdf

Proposed Motions (3): The Commission approves INN funding for this EHR Project in a total amount of $11,310,145.54 to be allocated among the three counties over a five-year period, as follows:

COUNTY	TOTAL INN FUNDING REQUESTED	DURATION OF INN PROJECT
Humboldt	Up to $608,678 in MHSA INN funding	5 Years
Sonoma	Up to $4,420,447.54 in MHSA INN funding	5 Years
Tulare	Up to $6,281,021 in MHSA INN funding	5 Years
	TOTAL: $11,310,146.54	

Mental Health Services
Oversight & Accountability Commission

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  iii. Commission staff will then share the link for innovation projects with the following recipients:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  i. When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  ii. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

Semi-Statewide Electronic Health Record Project
Biography CalMHSA Presenter

Dr. Amie Miller

Dr. Amie Miller is the Executive Director of CalMHSA (California Mental Health Services Authority). Prior to her role with CalMHSA Amie was the Behavioral Health Director for Monterey County.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS

SEMI-STATEWIDE ENTERPRISE HEALTH RECORD INNOVATION PROJECT

Innovation (INN) Project Name:	**Semi-Statewide Enterprise Health Record Innovation Project**
Collaborating Counties:	**Humboldt, Sonoma and Tulare***
Total INN Funding Requested:	**Up to $ 11,310,146.54**
Duration of INN Project:	**5 years**
MHSOAC consideration of INN Project:	**October 27, 2022**

Review History:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment
Humboldt	$608,678	5	05/25/2022-06/23/2022
Sonoma	$4,420,447.54	5	06/20/2022-07/19/2022
Tulare*	$6,281,021	5	03/08/2022-04/08/2022

Total: $11,310,146.54

*Tulare County was previously approved by the Commission in June 2022 to utilize up to $1,000,000 in INN funding for phase 1 planning of this project and is now seeking additional funding for phase two (implementation).

Project Introduction:

Humboldt, Sonoma and Tulare Counties are seeking approval to use innovation funds to partner with CalMHSA on the Semi-Statewide Enterprise Health Record Innovation Project (hereafter referred to as the EHR Project) along with approximately 20 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting, with the goal to **increase the quality of mental health services, including measurable outcomes and promote interagency and community collaboration.** Together, these 23 counties are collectively responsible for 4,000,000 (27%) of the state's Medi-Cal Beneficiaries.

Counties have prioritized this innovation project, at this time, in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current workforce and improve the quality of services during a time of rising need for mental health treatment services.

Identified Need

Electronic Health Records (EHR) have been identified as a source of burnout and dissatisfaction among healthcare direct service staff. **CalMHSA explains that EHRs were designed as billing engines and have not evolved to prioritize the user experience of either the providers or recipients of care resulting in an estimated 40% of a healthcare staff's workday currently spent on documenting encounters, instead of providing direct client care.**

Humboldt County states that they have been experiencing challenges in hiring and retaining clinicians for the past several years and have a 33.7% current vacancy rate for the clinician job classes. They state that since going live with their current EHR in 2014, clinical staff have frequently complained of difficulties associated with using the EHR, that the system is "not intuitive," it is difficult to find information within the system quickly and that practitioners suffer from "click fatigue."

Some examples of the current EHR not meeting the daily needs of clinicians in Humboldt County include (see pgs. 16-17 for additional details):

- The current EHR is built on an archaic version of JAVA script which can no longer be updated and is not ADA compatible.
- There is currently no way to give community- based organizations (CBOs) access with the current EHR that would be compliant with our privacy and security practices.
- EHR requires double and sometime triple entry into the progress notes with approval codes for missed and rescheduled appointments.

Humboldt county hypothesizes that the current EHR has negatively impacted the overall job satisfaction of the practitioners and may be a contributing factor to workforce retention.

Sonoma County has also struggled with hiring and retaining staff with a current 26% vacancy rate of the behavioral health positions. One of the reasons that staff state as **a contributing factor for terminating employment with the county is the cumbersome and time-consuming electronic health record system, Avatar.**

Sonoma County Behavioral Health currently utilizes 3 primary systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal).

Examples of the limitations Sonoma County experiences with their EHRs include (see pgs.43-44 for additional details):

- Struggles with implementing Federal and State requirements with our current EHR vendors and systems. The County has minimal resources to administer our systems,

and lack technical expertise in the areas of modification, enhancement, implementation and maintenance of our EHR systems.
- The County has been unsuccessful with implementing the use of AVATAR with local CBOs who provide 40% of mental health services.
- Current EHRs are not configured for full-system use, leaving us to manage via external spreadsheets, workarounds, and add-on databases.

Tulare County identifies that their mental health branch faces an increasingly complex task in the upcoming years (see pgs. 31-32 for additional details):
- Successfully integrate the California Advancing and Improving Medi-Cal state initiatives.
- Grow and retain a robust and dynamic workforce in a Health Provider Shortage Area through eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting; and
- Modernize an integrated health record system that can efficiently and effectively provide data for decision making, not just for care provision for the consumers served but also for administration as the County looks to performance outcomes and measures to successfully implement payment reform.

Tulare County's phase one Innovation investment into the EHR project has allowed the county to build the capacity and complete initial preparation to fully participate in the EHR Project. Phase one activities included:
- executing a participation agreement with CalMHSA
- hiring staff to support participation in the project
- participation in HCD activities
- connection with Los Angeles County to share the learnings from Hollywood 2.0
- focusing on the integration of local goals into the project including integrating substance use disorder services with mental health services.

Tulare County was the first county to work with their local community partners to connect identified needs with the opportunity presented by CalMHSA, complete local approvals, and has emerged as a leading thought partner helping to shape the collaborative learning goals and evaluation strategy. Tulare will continue to be a lead county to support the successful launch of the EHR Project.

In alignment with challenges reported by counties, CalMHSA continues to explain that the majority of EHR vendors develop products to meet the needs of the larger physical health care market, and that **the few national vendors who cater to the behavioral health market have been disincentivized from operating in California due to several unique aspects of the California behavioral health landscape.**

CalMHSA highlights three ongoing difficulties:
- Configuring the existing EHRs to meet the everchanging California requirements,

- Collecting and reporting on meaningful outcomes for all the county behavioral health services (including MHSA-funded activities), and
- Providing direct service staff and the clients they serve with tools that enhance rather than hinder care has been difficult and costly to tackle on an individual county basis.

CalMHSA states that the result is county behavioral health plans being dissatisfied with their current EHRs with few choices to implement new solutions.

The California Advancing and Innovating Medi-Cal (CalAIM) changes target documentation redesign, payment reform and data exchange requirements will bring California Behavioral Health requirements into greater alignment with national physical healthcare standards resulting in a lower-barrier entry for EHR vendors seeking to serve California.

CalMHSA proposes to maximize the opportunity presented by the CalAIM changes to support County Behavioral Health Plans to revamp their primary service tool to meet the current challenges by partnering with counties and launching the Semi-Statewide EHR initiative.

Initial MHSA Capital Facilities and Technological Needs (CFTN) funding allowed counties to acquire their first EHRs, catalyzing the transformation from paper charts to electronic documentation. While these electronic tools may have offered the best available solutions at the time, newer software solutions have evolved to meet current health industry standards such as privacy, security, and interoperability. These electronic records are used to document and claim Medi-Cal services that County Behavioral Health Plans (BHPs) provide and, if properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities shouldered by BHPs.

How this Innovation project addresses this need

California counties have joined together to envision an enterprise solution where the EHR goes far beyond its origins to provide a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system, hypothesizing that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Through the identification of challenges/shortcomings within existing (legacy) EHRs that contribute to key indicators of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County Behavioral Health Plans' workforce as well as the clients they serve.

In addition, the EHR Project is making a considerable investment in **ensuring that industry standards for privacy and security are central to the product.** CalMHSA is working with healthcare privacy legal experts to create master consenting documents to enhancing the opportunity for consenting clients to receive coordinated care.

The project identifies three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce must provide treatment services to our client population.
2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden.

The EHR will be collaboratively designed with national experts, counties, and the communities they serve through a human-centered design (HCD) process. CalMHSA states that the HCD approach is supported by research and is a key component of this project. By enlisting key community partners and providers to share their knowledge and expertise of daily clinical operations, the EHR project is more likely to offer informed solutions as part of the design that will help ensure the new EHR is responsive to the needs of the behavioral health workforce and the clients they serve.

The key principles of the EHR project include (see pages 4-5 for specifics):

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County Behavioral Health Plans.

- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems.

- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi- Cal claiming).

- **Lean and Human Centered:** CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety, and natively collects outcomes.

- **Interoperable:** Reimagining the clinical workflow so critical information about the people being served is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

Through a Request for Proposal competitive process, CalMHSA has selected Streamline Healthcare Solutions, LLC as the vendor for the development, implementation, and maintenance of the Semi-Statewide EHR. CalMHSA stated that their agreement with Streamline Healthcare Solutions includes non-compete terms and provisions for CalMHSA to maintain appropriate intellectual property rights for the customized, California EHR.

RAND is the selected evaluation vendor and will assist in ensuring the Innovation project is congruent with quantitative and qualitative data reporting on key indicators.

To support a more successful multi-county collaboration, CalMHSA has done a deep dive into the Help@Hand Innovation investment to incorporate lessons learned and to work toward implementing a shared decision-making model.

Discussion of County Specific Regulatory Requirements (see Appendices, pgs. 14-52)

Humboldt held their 30-day Public Comment Period May 25, 2022 through June 23, 2022 followed by their public hearing by the local Mental Health Board on June 23, 2022 and County Board of Supervisors' approval on July 19, 2022.

The desire to join the EHR Project was the result of community partners identifying the need to increase support for the behavioral health workforce as a theme for the 2020-2023 Three Year Plan and Expenditure Report and the 2022-2023 community program planning process. The County also hopes to obtain more accurate data through this project to address another identified theme of increasing culturally competent and bilingual services. The local community program planning process consisted of 72 individuals attending regional meetings including meeting with the Youth Advisory Board, Behavioral Health Board, and the Education Leadership Team.

Sonoma held their 30-day Public Comment Period June 20, 2022 through July 19, 2022, followed by a public hearing by the local Mental Health Board July 19, 2022 and County Board of Supervisors' approval on September 13, 2022.

The decision to join the EHR project was made after a community planning process that began in April 2022 with discussions between the county and a variety of community partners, including MHSA Community Program Planning (CPP) Workgroup, MHSA Steering Committee, Mental Health Board, Department of Health Services leadership, Division Management Team, Division CBO contractors and Board of Supervisors.

In addition, Sonoma held a meeting with CBO service providers about CalAIM and 3 listening sessions (Adult MH Providers, Youth MH Providers, Substance Use Disorder service providers) to provide an overview of anticipated system changes. CBO attendees included Program Directors, Clinical Directors, Quality Management Teams, and Billing/Claiming Teams. (See pages 45-48 for more details). The County reports that CBOs support participation in this project.

Tulare proposed this project plan in their MHSA Three-Year Program and Expenditure Plan. The corresponding public comment period was held March 8, 2022 through April 8, 2022 followed by local Mental Health Board hearing on April 5, 2022 and County Board of Supervisor's approval on June 14, 2022.

Tulare County is advised by an MHSA Community Partner Team consisting of representatives from agency partners, consumers of mental health services, family members of consumers of mental health services, mental health providers, faith-based organizations, community-based organizations, and community/cultural brokers. The County also has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians, and county staff.

The County states that throughout the last year, community partners in various committees, reviewed and discussed strategies to address the challenges related to employee satisfaction and retention, and how to modernize the electronic health record system.

Community Partner Feedback

This project was shared with community partners on May 18, 2022, when Tulare County proposed to join the collaborative with an initial phase one investment.

This project was again shared with community partners on July 6, 2022, when Sonoma County proposed to join the collaborative.

Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One comment was received in response to Commission sharing the Tulare and Sonoma plans with community partner contractors, the listserv, and Committees. The comment was shared with the county and was supportive of the proposal:

"When I first started this job, I was a bit surprised about how the insufficient amount of data. Not much can be said about the proposal. It's desperately needed. I like this program. I support it and look forward to following the development of the program".

The project was again shared on September 27, 2022 and October 12, 2022 when CalMHSA submitted a joint proposal on behalf of Humboldt, Sonoma and Tulare Counties.

One comment and one letter of opposition were received in response to Commission sharing the joint Humboldt, Sonoma and Tulare plan with stakeholder contractors, the listserv, and Committees. Both were shared with CalMHSA. The comment is provided below, and the letter is included as a handout:

"… the data is very clear and the project is needed.
I think it is at high cost and feel since the pilot is going to be closely monitored. There should be cutbacks and ways the funds can be shortened so it can be easily applied and then be part of an overage that can be shared with petty cash funds for a county that needs more?

Is Los Angeles County already using something more similar?
I see important data that is listed lacking in information also."

Learning Objectives and Evaluation:

CalMHSA estimates that the project could impact up to 14,000 EHR users throughout the state.

The EHR Innovation project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems.
2) **Design Phase**: Based on data gathered from the initial phase, HCD experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR.
3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

As a provider of services to CalMHSA through a master agreement and as an expert in California's behavioral health space, CalMHSA selected RAND to complete the EHR Project evaluation. RAND will assist in ensuring the project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the project planning phase. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention.

To ensure that the project is developed in a manner that is most in line with the needs of the behavioral health workforce and the diverse communities they serve, **RAND will subcontract with a subject matter expert in human-centered design.**

CalMHSA identified three project objectives with RAND (see pgs. 9-10 for more detail):

Objective I: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.

Objective II: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases.

Objective III: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

The Budget

Humboldt, Sonoma, and Tulare Counties are requesting authorization to spend up to $11,310,146.54 in MHSA Innovation funding for this project over a period of five (5) years.

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	CalMHSA	Evaluation	Sustainability Plan (Y/N)
Humboldt**	$608,678	$17,482	$441,196	$150,000 (24%)	Y
Sonoma	$4,420,447.54	In kind	$4,170,447.54	$250,000 (5.6%)	Y
Tulare*	$6,281,021	$2,430,221	$3,600,800	$250,000 (4%)	Y
Total	**$11,310,146.54**				

**Tulare was previously approved by the Commission in June 2022 to utilize up to $1,000,000 in INN funding for planning and phase one implementation of this project and is now seeking additional funding for phase two implementation.*
*** Humboldt County anticipates spending a total of $3,690,834 with the addition of Federal Financial Participation, Behavioral Health Subaccount, and American Rescue Grant funds.*

CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute participation agreements with each respective county, as well as contracts with the selected EHR Vendor and evaluator.

Humboldt will contribute a total of $3,690,834 to the project with $608,678 of the total from Innovation funds. Innovation will fund the following:

- Personnel costs total $17,482 to contribute towards county staff time
- Consultant and Evaluation costs of $591,196

Sonoma will contribute a total of $4,420,447.54 of innovation funds to the project with additional local costs for staff support being provided in kind through other funding sources. Innovation will fund the following:

- Consultant and Evaluation costs of $4,420,447.54

Tulare is requesting $6,281,021 of phase two implementation funding and will contribute a total of $7,281,021 to the overall project. Phase two funding is comprised of the following:

- Personnel costs total $ $2,017,221 to cover county staff expenses
- Operating costs of $ $413,000
- Consultant and Evaluation costs of $3,850,800

Sustainability and Dissemination (see Appendices, pgs. 14-52)
Each county has outlined how they will share the lessons learned from this investment and how they will continue to fund the new EHR system if the project is successful.

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

The Innovation Project Plan: Section 0: Multi-County Innovation Project Plan Participants:.
Project Title : Semi-Statewide Enterprise Health Record (HER) Innovation.

My position: Proposed project fails to meet the spirit or intent of the Mental Health Service Act and should not be funded with financial resources from MHSA.

The project does not make a change to existing practice in the field of mental health. The project is designed to change the location of clinical documentation and storing private, confidential personal information protected by HIPAA. [1] The project has a high potential of violating HIPAA's Privacy Rule and opens up vulnerabilities as reported by the CyberSecurity and Infrastructure Security Agency. Also, I am concerned that the project fails to designate HIPAA and cybersecurity subject matter experts in their personnel in designing the system. Cyber Security experts agree that there will always be weaknesses in securing the software supply chain.

The project fails to clearly address the HIPAA requirements of Privacy Rule Notification allowing every patient to 'opt in' having their confidential and private protected health information available for multiple person's accessing their clinical records without their knowledge.

Ransomware attacks on healthcare are particularly common in the US, with **41% of such attacks globally having been carried out against US-based firms in 2021**. The number of ransomware attacks on healthcare organizations increased 94% from 2021 to 2022, according to a report from the cybersecurity firm Sophos. More than two-thirds of healthcare organizations in the US said they had experienced a ransomware attack in 2021, according to the Sophos study , up from 34% in 2020. In 2021, there were 679 medical record breaches. On an average 1.95 healthcare data breaches of 500 or more records were reported each day. Mental health patients should be warned and given this information to make an informed consent to "opt in" this system. Per National Library of Medicine, "Even more alarmingly, the healthcare industry in particular is being targeted by attackers, and is therefore the most vulnerable."[2]

---

[1] 45 C.F.R. Part 160 and Part 164.

[2] Seh AH, Zarour M, Alenezi M, Sarkar AK, Agrawal A, Kumar R, Khan RA. Healthcare Data Breaches: Insights and Implications. Healthcare (Basel). 2020 May 13;8(2):133. doi: 10.3390/healthcare8020133. PMID: 32414183; PMCID: PMC7349636.

California's voters passed Proposition 63 (Mental Health Services Act / MHSA) in the November 2004 General Election. Proposition 63 promised to greatly improve the delivery of mental health services and treatment across the State of California.[3] This proposal does not meet the needs of increasing and training therapists, psychologists, and psychiatrists to provide quality psychological and psychiatric treatment to the consumers in California. In fact, the services are becoming worst.

[3] Dmh.lacounty.gov

AGENDA ITEM 8

Action

October 27, 2022 Commission Meeting

Elevating the Commission's Voice on Racial Equity: Racial Equity Plan

Summary: The Mental Health Services Oversight and Accountability Commission will consider the adoption of its Racial Equity Plan to acknowledge and address structural racism in California's mental health system and intentionally build racial equity strategies into Commission operations and priorities.

Background: The Mental Health Services Act was designed to drive transformational change in California's mental health system. In alignment with that aim, the Commission joined the Capitol Collaborative on Race and Equity in August 2020. CCORE is an initiative championed by the California Strategic Growth Council. It is led by Race Forward, a non-profit organization focused on supporting racial equity in government, with support from the Government Alliance on Race and Equity, the Public Health Institute, and the California Endowment.

The Commission engaged the Cultural Linguistic Competence Committee and the Client and Family Leadership Committee, along with community partners in developing this plan. The Commission also consulted with other State agencies and subject matter experts to gather information on best practices and community needs for inclusion in this plan.

The Commission has the opportunity in adopting its first Racial Equity Plan to leverage the strategies identified for transformational change in its Strategic Plan 2020-23.

Enclosure (1): Elevating the Commission's Voice on Racial Equity: Racial Equity Plan

Handouts (1): The presentation will be supported by PowerPoint slides.

Proposed Motion: The Commission approves the Racial Equity Plan.

ELEVATING THE COMMISSION'S VOICE ON RACIAL EQUITY

Mental Health Services Oversight and Accountability Commission

Racial Equity Plan

ABOUT THE COMMISSION

The Mental Health Services Oversight and Accountability Commission was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act (MHSA). The Commission provides oversight, accountability, and leadership to guide the transformation of California's mental health system. The 16-member Commission includes one Senator, one Assembly member, the State Attorney General (or a designee), the State Superintendent of Public Instruction (or a designee), and 12 public members appointed by the Governor. By law, the Governor's appointees are people who represent different sectors of society, including mental health peers, family members of people with mental health needs, law enforcement, education, labor, business, and the mental health profession.

COMMISSIONERS

MARA MADRIGAL-WEISS; Commission Chair, *Executive Director, Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education*
MAYRA E. ALVAREZ; Commission Vice Chair, *President, The Children's Partnership*
MARK BONTRAGER; *Director of Regulatory Affairs, Partnership HealthPlan of California*
JOHN BOYD, Psy.D.; *Chief Executive Officer, Hospital Division Rogers Behavioral Health*
BILL BROWN; *Sheriff, County of Santa Barbara*
KEYONDRIA BUNCH, Ph.D.; *Clinical Psychologist, Emergency Outreach Bureau, Los Angeles County Department of Mental Health*
STEVE CARNEVALE; *Executive Chairman, Sawgrass*
WENDY CARRILLO; *California State Assemblywoman, District 51*
RAYSHELL CHAMBERS; *Co-Executive Director and Chief Operations Officer, Painted Brain*
SHUO CHEN; *General Partner, Innovation Overflow-IOVC*
DAVE CORTESE; *California State Senator, District 15*
ITAI DANOVITCH, M.D.; *Chair, Department of Psychiatry and Behavioral Neurosciences, Cedars-Sinai Medical Center*
DAVID GORDON; *Superintendent, Sacramento County Office of Education*
GLADYS MITCHELL; *Staff Services Manager, California Department of Health Care Services and California Department of Alcohol and Drug Programs (Retired)*
ALFRED ROWLETT; *CEO, Turning Point Community Programs*
KHATERA TAMPLEN; *Consumer Empowerment Manager, Alameda County Behavioral Health Care Services*

_____

ANNA NAIFY, Psy.D.; *Consulting Psychologist*
LAUREN QUINTERO; *Chief, Administrative Services*
TOBY EWING, Ph.D.; *Executive Director*

ACKNOWLEDGEMENTS

The Commission wants to thank those who dedicated their time and creative energy to this Racial Equity Plan. Thank you to Vice Chair Mayra E. Alvarez and Executive Director Toby Ewing who championed this work. Without their support this plan would not have been possible. Meaningful

discussions on race can be challenging in the current social environment. We appreciate the efforts of many to develop this plan including:

Anna Naify (co-lead)
Lauren Quintero (co-lead)
Andrea Anderson
Marcus Galeste
Latonya Harris
Vicque Kimmel
Kayla Landry
Amanda Lawrence
Kai LeMasson
Tom Orrock
Norma Pate
Grace Reedy
Lester Robancho
Cody Scott
Sharmil Shah
Reem Shahrouri

This Racial Equity Plan was developed by Commission staff with input and guidance from the Commission's Cultural and Linguistic Competence Committee and the Client and Family Leadership Committee, along with many other community partners who provided valuable input into this planning process. The Commission is grateful to all who contributed.

As a member of The Capitol Collaborative on Race & Equity (CCORE) network, the Commission shared learning with the other State agencies and departments in the 2020–2021 CCORE cohort. Those agencies are listed in Appendix A. The Commission would like to thank all the agencies and departments in the CCORE cohort for their guidance and thoughtful feedback during the planning process.

Special thanks are also extended to Tamu Green, Ph.D., who served as a consultant to support the Commission staff in developing this plan and enhancing our learning opportunities. Dr. Green met with the team every other week for more than a year, providing supplemental training and creating a safe and brave space for staff to discuss racial equity.

INTRODUCTION

The Mental Health Services Oversight and Accountability Commission seeks to address structural racism and disparities by recognizing that California's mental health system has not been designed with an equity lens. Bias and discrimination in our communities, including within the mental health system, must be addressed, and cultural competency and attention to disparities must inform mental health programs and practices. Through this Racial Equity Plan, the Commission can acknowledge and address structural racism in the mental health system. The Commission also understands that race is one element of our intersectional lives, and we are impacted by multiple intersecting layers of opportunities, biases, and challenges. Thus, the Commission acknowledges that to transform California's mental health system, our work cannot stop with racial equity and must be applied to other disparities that meaningfully impact the lives of all Californians. This plan is designed to intentionally build racial equity strategies into Commission operations and priorities.

Disparities Persist as a Result of Structural Racism

Structural racism results in and supports continued disadvantages to people of color including access to basic needs, housing, and education. Structural racism is also widespread in healthcare systems, including the mental health care system. That reality has led to a significant distrust of health care providers and programs among communities of color. Distrust, paired with additional challenges tied to bias and discrimination, leads to lower rates of screening, diagnosis, and service utilization, which collectively lead to poorer health outcomes.

Mental Health Services Act

The Mental Health Services Act was designed to drive transformational change in California's mental health system. The Commission is charged with oversight, advising the Governor and Legislature, and supporting transformational change. Included in the goal of transformational change is prioritizing community engagement, including cultural humility, wellness and recovery, and prevention and early intervention.

Capitol Collaborative on Race and Equity

In 2020, to support the goal of advancing racial equity, the Commission joined the Capitol Collaborative on Race and Equity, an initiative championed by the California Strategic Growth Council. CCORE is led by Race Forward, a non-profit organization supporting racial equity in government. CCORE also enjoys support from the Government Alliance on Race and Equity, the Public Health Institute, and the California Endowment.

To date, the CCORE initiative has engaged 37 state agencies to improve their knowledge and understanding of racial equity, implicit bias, and how to dismantle structural racism that creates disparities. Those agencies are listed in Appendix A. The CCORE initiative is designed to educate and encourage state agencies to develop racial equity plans and, through this strategic planning process, recognize opportunities to address disparities and support racial equity.

Statewide Efforts on Racial Equity

The Commission's work in this area is aligned with statewide efforts to address racial equity. In March 2021, representatives from California's county behavioral health, human services, public health, and public hospital systems released a statement declaring that racism is a public health crisis. In their statement, these community leaders acknowledged the persistence of racism as a

social determinant of health that directly impacts diverse communities (County Leaders Statement on Racism as a Public Health Crisis, 2021).

California's former Surgeon General, Dr. Nadine Burke Harris advocated for increased attention to systemic racism and its impact on health outcomes. She highlighted how segregated communities and employment discrimination lead to unequal distribution of resources and health access. Toxic stress and exposure to adverse childhood experiences resulting from the uneven distribution of resources has led to long-term health problems. She has written that "Racist oppression ensures that black and brown children bear a disproportionate burden of dehumanizing and traumatic experiences. Science shows it is sickening them and killing them" (Harris, 2020).

TRANSFORMATIONAL CHANGE IN MENTAL HEALTH

The Commission's strategic plan, developed in consultation with clients and families, community advocates, providers, and others, affirms the Commission's commitment to using its authority, resources, and passion to reduce the adverse outcomes of unmet mental health needs and promote the wellbeing of all Californians. As part of its strategic plan, the Commission's mission statement reflects its vision and values:

MISSION STATEMENT

The Commission works through partnerships to catalyze transformational changes across service systems so that everyone who needs mental health care has access to and receives effective and culturally competent care.

To be successful, it is essential to acknowledge and address racial inequities and the structural racism that impedes pursuit of that mission.

RACIAL EQUITY PLAN

One of the most powerful tools the Commission has is its voice. To begin this work, the Commission endorses the following racial equity declaration. This declaration marks a commitment to the overarching goal of racial equity in California's mental health system.

RACIAL EQUITY DECLARATION

The Commission acknowledges that racism, discrimination, and bias have negatively impacted mental health outcomes in California both historically and persistently. The Mental Health Services Act explicitly calls for addressing disparities and racial equity in mental health. The Commission commits to recognizing historic harm, to working in collaboration with California's diverse communities to remedy this harm, and striving for equity in all our work.

PRIORITIZING EQUITY IN THE COMMISSION'S WORK

To promote racial equity in California's mental health system, the Commission will leverage its internal operations, as well as its work in policy research and development, grantmaking, data and evaluation research, communications, and community outreach and support, as follows:

COMMISSION MEETINGS

The Commission will address racial equity in its core operations, including in the design and planning for meetings of the Commission and related activities.

Strategies to address equity in Commission meeting planning include:

- ✓ Exploring meeting locations and site visits within diverse communities to increase public accessibility.
- ✓ Ensuring translation services are available.
- ✓ Engaging minority-owned businesses in contracting for meetings and related services.
- ✓ Identifying speakers who represent diverse, local communities.
- ✓ Including land acknowledgements in Commission and related meetings.

Land Acknowledgements

The Commission will honor Indigenous people as traditional stewards of California's lands by including formal statements of recognition and respect, referred to as a "Land Acknowledgement." The intent is to demonstrate the Commission's understanding of the historic and current impact of colonization on Indigenous people. This statement aims to recognize and respect the relationship between Indigenous people and their traditional territories. Incorporating land acknowledgements into meetings is a minor step and, to be impactful, must be coupled with actions. The Commission recognizes Native American tribal governments as sovereign, self-governing agencies that are responsible for the health, safety, and welfare of their citizens; and is committed to enhanced collaboration and support. Intergovernmental coordination efforts between tribes and states and effective tribal–state relationships are essential for providing indispensable mental health services for all Californians. Commission staff will work with the Commission's Chair to identify strategies beyond land acknowledgements to enhance the understanding of tribal mental health needs and strengthen opportunities to address them.

DIVERSITY, EQUITY, AND INCLUSION IN COMMISSION STAFFING

Considering its own personnel operations is foundational to the Commission's endeavor to address racial inequity. By implementing best practices to recruiting, hiring, and retaining diverse staff, Commission staff will be able infuse diverse perspectives and practices into their work. This focus will lead to accessing a greater range of talent, insight into needs and motivations of all consumers, attunement to blind spots, and, ultimately, better decision making.

The Commission will:

- ✓ Review and implement best practices in diversity, equity, and inclusion in recruiting, hiring, training, promoting, and retaining its staff, and support professional development for its staff.
- ✓ Partner with other state agencies, leading organizations, and others that embrace diversity, equity, and inclusion standards.
- ✓ Measure and monitor progress in achieving diversity, equity, and inclusion standards for the Commission's workforce.

INCENTIVIZING RACIAL EQUITY IN GRANT FUNDING

The Commission is a significant grant provider to California's mental health system and the Commission has used its grantmaking authority to incentivize transformational change and improved mental health outcomes. The Commission is committed to addressing racial equity through its grantmaking role. The Commission will:

- ✓ Review and implement best practices in supporting racial equity through contracting and grantmaking, including engaging California's philanthropic, community to replicate successful practices focusing on achieving racial equity.
- ✓ Review State contracting rules and requirements to ensure contracting work is consistent with the law and solicit support from the Department of General Services and other control agencies to understand and implement best practices in contract and grantmaking operations with respect to diversity, equity, and inclusion.
- ✓ Leverage partnerships, including but not limited to members of the Cultural and Linguistic Competency Committee, advocacy contractors, and others to strengthen grant programs in ways that reduce disparities.
- ✓ Provide technical assistance to grant applicants and contractors, to develop methods to measure and reduce racial disparities and enhance community engagement in Commission funding opportunities.
- ✓ Measure, monitor, and publicly report progress on addressing racial equity.

INNOVATION

The MHSA includes a rare and explicit commitment to fostering innovation in providing services and support, including strategies to improve access to care and outcomes for underserved and unserved communities. To promote racial equity in innovation, the Commission has identified two strategies:

- ✓ Facilitate opportunities for counties to join the Multi-County Innovation Collaborative on Reducing Disparities in Mental Health, an initiative that is already underway.
- ✓ Provide technical assistance to help counties consider disparities and racial equity during the innovation planning process.

The Commission will offer a tool for counties to use when submitting their innovation projects for review and approval. The following are examples of questions that relate to equity:

- Defining the problem: Describe how racial disparities were assessed when determining the need for this project.
- What is the innovation: How will the innovation aim to reduce racial disparities?
- Evaluation: How will the evaluation assess the impact of the innovation on racial disparities? Are the evaluation measures culturally appropriate?

RESEARCH AND EVALUATION

The Commission uses data to provide information to the public and inform decision making. To address equity in research and evaluation the Commission will:

- ✓ Ensure that diverse voices are included in the Commission's research and data work, including research on disparities and equity.
- ✓ Recognize racial equity in all aspects of the Commission's research and analysis.
- ✓ Leverage and publicize data that identifies racial and ethnic disparities and encourage data collection that helps to better understand those disparities.

POLICY RESEARCH

The Commission has completed policy projects in the areas of criminal justice, suicide prevention, and school mental health. Currently, the Commission is working on projects regarding prevention and early intervention in mental health and workplace mental health. All policy projects include engagement with diverse communities. In the Commission's current work and moving forward it will:

- ✓ Ensure the voices of diverse communities are included in policy research.
- ✓ Work with subject-matter experts to identify best practices of policy research that address disparities.
- ✓ Explore and describe structural racism in policies related to the mental health system.
- ✓ Emphasize recommendations or solutions with the potential to reduce disparities and negative outcomes among diverse racial/ethnic communities.

COMMUNICATIONS

Communication strategies are powerful tools to address disparities and stigma about mental health. Videos, social media strategies, testimonials, and printed materials can tell stories that are relatable and that convey powerful messages to the public about race and mental health. To leverage communication tools to address racial equity, the Commission will:

- ✓ Engage diverse partners in storytelling and developing communication strategies.
- ✓ Elicit expertise from various communications media professionals to identify best practices on how to reach diverse audiences, how to represent diversity and inclusion in communications materials, and how to communicate about race.
- ✓ Leverage media to communicate about disparities in mental health, stigma, and opportunities to advance racial equity in the mental health system.

ACCOUNTABILITY AND NEXT STEPS

The Commission acknowledges that this plan is only an initial step in eliminating disparities in California's mental health system. There is more work to be done in collaboration with other state departments and communities to further this effort. While working on the steps outlined in this document, the Commission will strive to enhance communication on strategies to address racial disparities and engage community partners to assess progress and to troubleshoot emergent barriers. Through ongoing consultation with subject matter experts, such as the Cultural and Linguistic Competency Committee, the Commission will revisit this plan to make any needed changes and identify additional opportunities to meet its racial equity vision. Equity work is never finished, and the Commission will strive to address equity for all Californians while working toward its overall goal: to transform the mental health system so that everyone who needs mental health care has access to and receives effective and culturally competent care.

Appendix A: CCORE Participating State Departments and Agencies

2020-2021 Learning Cohort

- Department of Aging
- Conservation Corps
- Fi$cal
- Department of Fish & Wildlife
- Department of Food & Agriculture
- Department of Forestry & Fire Protection
- Housing Finance Agency
- Mental Health Services Oversight & Accountability Commission
- Office of Planning & Research
- Public Utilities Commission
- Tahoe Conservancy
- Transportation Agency
- High Speed Rail Authority
- Highway Patrol
- Department of Motor Vehicles
- New Motor Vehicle Board
- Office of Traffic Safety
- Caltrans
- Transportation Commission
- Department of Water Resources
- California Department of Housing and Community Development
- California Department of Transportation
- California Department of Education
- California Department of Corrections and Rehabilitation
- California Department of Community Services and Development
- California Department of Social Services
- California Environmental Protection Agency
- Air Resources Board
- CalRecycle
- Department of Pesticide Regulation
- Department of Toxic Substances Control
- Office of Environmental Health Hazard Assessment
- State Water Resources Control Board
- California State Lands Commission
- California Strategic Growth Council & Governor's Office of Planning and Research

2018-2019 Learning and Implementation Cohorts

- California Arts Council
- California Coastal Commission
- California Department of Public Health

AGENDA ITEM 9

Action

October 27, 2022 Commission Meeting

Innovation Implementation Plan

Strengthening MHSA Innovation through a Culture of Learning and Collaboration

Summary: In 2017 the Commission directed staff to explore opportunities to enhance the impact of MHSA Innovation Funds and formed a Subcommittee on Innovation to guide that work. Led by Commissioners John Boyd and Itai Danovitch, the Subcommittee has reviewed and approved a series of recommendations for strengthening county and commission work on innovation. Those recommendations focus on 1) supporting counties to develop innovation proposals with an enhanced likelihood of being transformative, 2) strengthening the Commission's review and approval process, and 3) facilitating learning across counties and among other partners.

The Commission contracted with a non-profit consultant – Social Finance – to support this work. Following more than 100 interviews and engagement meetings, Social Finance developed a series of recommendations that fall into eight categories. Recognizing time and resource constraints, Commission Staff is recommending a focus on a core set of those recommendations, rather than the full array of opportunities.

Included in the Commission's materials is an Innovation Action Plan (Appendix A) created by Social Finance that identifies more than 300 challenges, in the eight categories, for strengthening the innovation component of the MHSA. The attached graphic - Recommendations Prioritization Matrix (Appendix B) - highlights those eight categories and provides context for their consideration, such as time and resource requirements.

Catalyzing Transformational Change

To support the Commission's goal of supporting transformational change through innovation, Commission Staff is recommending focusing on three core areas of opportunity as shown in the Innovation Implementation Plan below:

Mental Health Services Oversight & Accountability Commission
Innovation Implementation Plan

Help Counties Develop Transformative Innovation Projects	Strengthen Commmission's Review Process	Facilitate Learning Among Counties
• Develop FAQ • Develop community engagement resources • Review support tools • Expand technical assistance	• Develop simplified project summary • Create a discussion guide for reviewers • Enchance support for Commissioners	• Develop case studies of stand-out projects • Create a data base of outcomes • Launch an Innovation Summit

1. **Goal: Help Counties Develop Transformative Innovation Projects**

County and community partners have reported challenges with: understanding the requirements of innovation proposals, what is necessary to obtain Commission approval and how best to engage communities in the development of their proposals. To address those needs, Social Finance has recommended the following:

Action:

- Develop a Frequently Asked Questions document that clarifies the innovation plan requirements in the Commission's regulations. The FAQ should be designed to reinforce the purpose and definition of innovation and inform and support innovation proposals with a higher likelihood of resulting in transformational innovations that can be scaled.
- Engage community and county partners to develop a community engagement resource to support the ability of counties to strengthen local engagement, including empowering local voices, perspectives, and alternative strategies for developing plans, such as human-centered design.
- Periodically convene counties and community partners to assess the impact of these resources, the need for refinements and/or alternative approaches.
- Expand the Commission's existing capacity to offer technical assistance and capacity building support to counties and community partners, consistent with its work on the alcove™ grant program, early psychosis, and school mental health, with a focus on Commission identified priorities that can be transformative.

2. **Goal: Strengthen the Commission's Innovation Proposal review process**

Commissioners have expressed concern that the MHSA innovation component has not generated sufficient system-level reforms and that successful innovations are slow to scale. County leaders also have expressed frustration that it is unclear what the Commission is

looking for when reviewing innovation proposals. To address those needs, Social Finance has recommended the following next steps:

Action:

- Develop a simplified Innovation Project Summary that focuses on the problem to be addressed, key community concerns, community involvement in innovation proposal development, the potential for the innovation to be transformative and/or scalable, key lessons to be learned through evaluation, and how will the proposal be implemented, including budget and evaluation.
- Create a discussion guide for the Commission and others to use when reviewing innovation proposals.
- Enhance support for Commissioners through the development of innovation-specific orientation materials for Commissioners, including staff briefings, and sample plans.

3. Goal: Facilitate learning across and within counties

Commissioners have raised concern that lessons from innovation proposals rarely make their way across county lines, limiting the opportunity for learning and replication and adaptation by other counties. To address that issue, Social Finance recommended the following:

Action:

- Develop and disseminate case studies of stand-out practices and processes used to design and implement innovation proposals.
- Create a database of innovation projects with qualitative and quantitative outcomes, information about the population of focus, and other important elements of each project.
- Design and launch an Innovation Summit to 1) share learnings and celebrate successful innovations, 2) identify key priorities for transformative innovations, and 3) expand awareness of the innovation component of the MHSA and identify new partners to support its success.

Next Steps

Commission Staff are seeking authorization to move forward with these recommendations. The Commission may need to seek additional staff and financial resources to support the full array of recommendations included here

Enclosures (2): (1) Appendix A-MHSOAC Systems Analysis Inn Action Plan (IAP); (2) Appendix B-Recommendation Prioritization Matrix

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

Proposed Motion: The Commission approves the Innovation Implementation Plan and directs staff to seek the financial resources and additional staff necessary to carry out the Plan's recommendations.

Appendix A

Innovation Action Plan

Deliverable 4, MHSOAC Incubator Systems Analysis Project

August 2021 ***(Updated October 2021)***

PREPARED FOR:

Mental Health Services
Oversight & Accountability Commission

Table of Contents

Executive Summary

Introduction

Included below is a summary of recommendations for the Mental Health Services Oversight and Accountability Commission (MHSOAC) about innovation and continuous improvement processes. We are eager for further conversation and reactions to each of the recommendations from Commissioners, members of the MHSOAC staff, County leaders, stakeholder advocates, and consumers and family members served by the public mental health system.[i]

At their core, these recommendations are about better collaboration and more in-depth learning. The MHSA's Innovation mandate is extraordinary and extraordinarily unusual: it sets aside a significant funding stream to plant the seeds for, and to test, "promising approach[es]…to persistent mental health challenges."[ii] We need these new approaches desperately, as the public mental health system has often been far too slow to translate programmatic solutions to systemic transformation,[iii] and to correct persistent disparities in care and outcomes.[iv] Through conversations with members of the Innovation community,[v] we have come to understand Innovation as both a process and an outcome: a practice of holistically including community members in defining local priorities, and a call to investigate how to better achieve those priorities.

The Commission's role in this is and should be about more than approving or rejecting plans. The Commission should embrace an enhanced role in shaping an ecosystem around learning and collaboration. California's 58 counties are hugely different from one another, but what they learn (results, operations assessments, costs) and how they learn it (community engagement, evaluation planning) through Innovation programs can inform others. The Commission is uniquely positioned to support increased learning and should focus its efforts to advance this goal.

The recommendations here are in service of this grander vision. Though many of them are modest in scope, they all suggest ways that, through more supportive and effective processes, the Commission can strengthen a culture of learning and collaboration, continuous improvement, and thoughtful risk taking – while skirting the real risk of adding further complexity and process to the public mental health system.

Obstacles to Innovation

The Systems Analysis project, which these recommendations are a part of, began with a wide-ranging series of interviews to identify obstacles to innovation. We discussed these obstacles in an October 2020 meeting of the Innovation Subcommittee, and documented them—along with detailed feedback from members of the Innovation community—in the "Barriers and Acceleration Agenda" (December).[vi]

Those we spoke with identified nearly three hundred challenges they faced in developing transformative Innovation Plans. We summarized these into seven categories: (i) limits on County capacity to invest deeply in Innovation planning, especially for small and frontier counties; (ii) complexities of local politics and alignment; (iii) limited data infrastructure, the challenges of evaluation, and slow dissemination of learning across Counties; (iv) the time, resources, and risks that go into developing Innovation Plans; (v) misalignments across Counties, Commissioners, and stakeholders about what constitutes a strong Innovation Plan; (vi) uneven stakeholder engagement across Counties and Plans; and (vii) the short-term

nature of Innovation funding. The recommendations in this document incorporate insights across these barriers, and focus on the following themes:

- Greater clarity about how Innovation funds can be used (and in particular, the definition of innovation itself[vii]); how Innovation Plans are assessed (including stronger guidance on what a good Plan looks like that meets the requirements for Plan approval); and, especially, what Innovation Projects are learning (across counties).

- More effective and meaningful community engagement in the design of Projects, informed by an improved understanding of what can be funded through Innovation and how Innovation Plans are assessed.

- More consistent, nuanced, and earlier feedback in the Innovation Plan approval process—while still operating under the realities of a volunteer Commission and limited resources.

Summary of Recommendations

The recommendations that follow are intended to help overcome these challenges. Many of these ideas were proposed at the same time as the barriers; others came from focus groups, surveys, and input from partners, in particular the California Association of Mental Health Peer-Run Organizations (CAMHPRO) and National Alliance on Mental Illness (NAMI) California and local affiliates.[viii] The body of this Innovation Action Plan consists of more in-depth information about each recommendation.

1. **Supplement the definition of innovation with further guidelines.**

    a. **Create an Innovation FAQ resource** to clarify areas of ongoing uncertainty (e.g., "How is 'new' defined in the context of MHSA Innovation?," "What magnitude of change or adjustment is needed to qualify as innovative learning?").

    b. Develop a publicly available (non-exhaustive) **list of types of projects that would qualify as "innovative."**

2. **Expand and deepen technical assistance to Counties.**

    a. **Strengthen support functions to meet County needs**, focusing on culturally competent community engagement, evaluation planning and performance management, and sustainability planning. In addition, work with others in the Innovation ecosystem to curate and disseminate resources to support County efforts, drawing from successful efforts from the California Reducing Disparities Project (CRDP) Phase 1 and Innovation Incubator projects.

    b. **Consider forming an "Innovation Support Group"** made up of a rotating group of experts from the Innovation community (e.g., representatives from the Client and Family Leadership Committee [CFLC] and the Cultural and the Linguistic Competency Committee [CLCC], stakeholder advocacy group members, MHSOAC staff Innovation Team, prior or current County staff with experience in MHSA Innovation, etc.) to meet

regularly and listen to emerging County draft plan concepts–with the goal of offering perspectives and supportive early guidance to counties seeking additional support. This group should be trained on the intricacies of Innovation and compensated when appropriate.

3. **Further clarify expectations for Plan development** and highlight what the Commission is looking for in Innovation Plans.

    a. **Simplify the Innovative Project Plan Recommended Template** by removing duplicative elements and orienting the template around key questions.

    b. **Create a discussion guide for the Commission and others to use when assessing Plans**, closely connecting the guide to the Innovative Project Plan Recommended Template (to guide County staff) and MHSOAC Staff Analysis. The purpose of the discussion guide is to suggest sample questions for how the Commission can review Plans (in part or whole) and lift up key questions that each plan should be able to answer.

    c. **Develop target dates for submitting Plan concepts and drafts to MHSOAC staff**, allowing enough time for meaningful technical assistance from the MHSOAC, and encourage Counties to submit Plans far in advance of reversion, deescalating the "do-or-die" last-minute approvals.

4. Develop mechanisms to **accelerate the diffusion of learnings** from Innovation Projects.

    a. **Publish case studies of stand-out practices and processes** Counties have used to design and implement Innovation Plans to share lessons learned with the Innovation community.

    b. **Host an annual Innovation convening.** The intention of these meetings is to accelerate cross-County learning: to present project-end synopses and lessons learned, make connections across Counties with similar challenges or developing similar projects, and attend workshops and training sessions relevant to Innovation.

    c. **Create a database of Innovation Projects** with qualitative and quantitative project outcomes, information about the project's population of focus, and other important elements of the project.

    d. **Require Counties to present concise outcomes and findings summaries at Commission meetings** by adding project readouts to the meeting agenda.

5. **Test a multi-stage approval process** that provides concept approval (e.g., that a Plan is innovative, and that it has been generated through an appropriate Community Program Planning [CPP] process) earlier in the Plan development cycle, while allowing time for Counties to further develop evaluations, operations, and sustainability plans before final approval.[ix]

6. **Develop a supplemental community engagement resource for Counties** that need additional support, that identifies tactics to strengthen local community engagement (drawing from the example CRDP Phase 1's work among African American, Latinx, Native American, Asian and Pacific Islander, and LGBTQ priority populations to build collaborative infrastructure and practice), sets expectations on what in the Innovation Component should and can be achieved through the CPP process, and provides guidance on how to bring forward local voices and perspectives in Innovation Plans submitted to the MHSOAC.

7. **Further publicize and clarify existing flexibilities that strengthen County planning processes**, including opportunities for accessing planning fund for Innovation Projects, delegated authority and the consent process, and deeper technical assistance through the MHSOAC (e.g., through the Innovation Incubator).

8. **Develop additional orientation materials for new Commissioners.** In addition to existing onboarding resources and a staff-led onboarding session, include details on barriers to innovation and learnings from recent Innovation Projects. Encourage Commissioners to hold introductory conversations with members of the Innovation ecosystem, and to attend a selection of Committee and Subcommittee meetings to gain a better understanding of key issues facing each. Make "refresher" trainings available to existing Commissioners.

Implementing these Recommendations

In the body of the Innovation Action Plan, we have included a proposed set of next steps for each of the recommendations above. To assist the MHSOAC with deciding to what extent, when, and how to implement these recommendations, we have categorized them based on the level of effort and next steps required:

- **Recommendations that are "quick wins" and relatively easy to implement:**
  - 1a. Create an Innovation FAQ resource to clarify areas of ongoing uncertainty
  - 3a. Simplify the Innovative Project Plan Recommended Template by orienting the template around key questions
  - 3c. Develop target dates for submitting Plan concepts and drafts to MHSOAC staff
  - 4c. Create a database of Innovation Projects with qualitative and quantitative project outcomes, information about the project's population of focus, and other important elements of the project
  - 4d. Require Counties to present outcomes and findings at Commission meetings by adding Project readouts to the meeting agenda at the conclusion of each Innovation Project
  - 7. Publicize and clarify existing flexibilities that strengthen County planning processes
  - 8. Develop additional orientation materials for new Commissioners
- **Recommendations that require convening members of the Innovation community to inform implementation:**
  - 1b. Develop a sample list of types of projects that would qualify as "innovative"
  - 2b. Consider forming an "Innovation Support Group"
  - 3b. Create a discussion guide for Commissioners and others to use when assessing plans

    - 5. Test a multi-stage approval process that provides concept approval earlier in the Plan development cycle
    - 6. Develop a community engagement resource for Counties, identifying tactics for deeper community engagement and lessons learned
- **Recommendations that might require asking for additional funding from the legislature:**
    - 2a. Strengthen support functions to meet County needs (funding for increased specialized technical assistance and an additional capacity to the MHSOAC staff Innovation Team)
    - 4b. Host an annual Innovation convening (funding for staff time, venue fees, speaker fees, refreshments, etc.)
- **Recommendations that could be implemented by organizations other than the MHSOAC:**
    - 2a. Strengthen support functions to meet County needs
    - 4a. Publish case studies of stand-out practices and processes Counties have used to design and implement Innovation Plans

Next Steps for the Systems Analysis Project: Resource Library

In tandem with this Innovation Action Plan, we are preparing a series of resources to support Counties in the development and planning of Innovation Projects. These resources will be packaged into a resource library ultimately available to Counties, and continuously updated to reflect new guidance and opportunities within Innovation. Recommendations for resources within this document have been noted within.

For more information about these recommendations or the Incubator Systems Analysis project generally, please contact Jake Segal (jsegal@socialfinance.org), Emily McKelvey Carpenter (ecarpenter@socialfinance.org), and Kyle Doran (kdoran@socialfinance.org).

---

[i] These recommendations draw from a range of inputs, including interviews with approximately 100 County leaders, community stakeholder advocates, consumers, family members, MHSOAC staff, and others; four meetings of a 16-person multi-sectoral project focus group; a survey of MHSA Coordinators, garnering 55 responses, and subsequent focus groups to glean more insights; and background research on analogous innovation processes and lessons from other contexts.

[ii] CCR § 3910(d).

[iii] This is not unique to the public mental health system, nor to California. The average time for research evidence to become standard practice is 17 years. See, e.g., JM Westfall et al, "Practice-based research – "Blue Highways" on the NIH roadmap," JAMA, 2007. For non-medical treatments, that timeline may be slower still. Access to and uptake of high-quality psychosocial treatments, "unlike new medications…rarely are encouraged by commercial marketing." See, e.g., Robert Drake et al., "What Explains the Diffusion of Treatments for Mental Illness?," Am J Psychiatry, November 2008.

[iv] See, among many others, a recent discussion in disparate mental health outcomes among racial and ethnic minorities in McKnight-Eily "Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic," CDC's MMWR Morb Mortal Wkly Rep, Feb 2021;70:162–166; and, among many others, a less-recent review of SAMHSA's NSDUH results in Medley et al., "Sexual Orientation and Estimates of Adult Substance Use and Mental Health: Results from the 2015 National Survey on Drug Use and Health," SAMHSA NSDUH Data Review, Oct 2016.

[v] We define here the "Innovation community" as those involved or directly impacted by the MHSA Innovation Component (e.g., County leaders, stakeholder advocates, consumers, family members, MHSOAC staff).

[vi] The "Barriers and Acceleration Agenda" can be found at https://socialfinance.org/wp-content/uploads/2020.12-Systems-Analysis-Deliv.-2-Barriers-Acc.-Agenda.pdf.

[vii] In many ways, this is natural: innovation as a term is notoriously challenging to define (see, e.g., "Why Innovation Is Tough to Define — and Even Tougher to Cultivate," *Knowledge@Wharton,* Aug 2013), and the MHSA itself ensures a broad set of innovation focus areas, including "administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for services providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions, including prevention, early intervention, and treatment" (CCR § 3910(d)). We discuss this challenge—and the sometimes problematic heuristics many have employed in considering innovation—in more depth in the full set of recommendations.

[viii] More information about the methods we used to solicit ideas and feedback are included in the Methodology section of the full plan.

[ix] This concept approval would be similar to the initial approval Counties have if they sign on to a Multi-County Collaborative.

Methodology

To develop the forthcoming set of recommendations, we gathered information from a variety of sources. Our process to understand the challenges and potential solutions facing MHSA Innovation surfaced a wide range of perspectives and feedback. We aimed to incorporate each of these perspectives as we built out and refined our recommendations.

- **Barriers interviews:** Conducted ~100 interviews with Commissioners, County leaders, stakeholder advocacy groups, consumers & ACCESS Ambassadors, state partners, MHSOAC staff, and Innovation Incubator technical assistance providers, to understand barriers to Innovation. Requested and reviewed detailed written feedback from ~eight interviewees on the barriers list.
- **CBHDA MHSA Committee meetings:** Coordinated with CBHDA leadership to join three monthly MHSA Coordinator meetings to gather verbal and written feedback regarding barriers to Innovation and potential solutions; facilitated survey of MHSA Coordinators (n=55).
- **Published reports:** Reviewed literature of available published reports about MHSA Innovation including a 2018 report from the California Pan-Ethnic Health Network (CPEHN) and LBGT Health and Human Services Network title "MHSA Innovation Recommendations," CALBHBC's Community Program Planning Process Guidelines, ACCESS California's 2019-2020 Stakeholder Inclusion and Feedback Survey, and the CRDP Strategic Plan.
- **Innovation Plan review:** Aggregated elements from 102 Innovation Plans and conducted analysis to identify trends and themes in plans submitted between 2017 and 2020.
- **Collaboration with contracted partners:** Partnered for ~12 months through subcontracts to engage in biweekly meetings with former County Behavioral Health Director, CAMHPRO, and NAMI California to leverage their expertise, and gather ongoing guidance and feedback.
- **Interviews on Innovation case studies:** Identified Innovation Projects with promising practices to develop case studies of effective Innovation projects and facilitated conversations with MHSA Coordinators and other partners to draft case studies.
- **Interviews to learn about public behavioral health innovation beyond California:** Initiated six interviews with experienced leaders focused on behavioral health innovation in the public sector in communities outside of California to gather insight into additional ways to support innovation.
- **Research on public-sector innovation:** Conducted secondary research on innovation in the public sector to understand (1) continuous improvement processes aimed at assessing, monitoring, and adjusting practices to make ongoing improvements, and (2) different types of innovation, including how to define and implement them.
- **Research on multi-stage approval processes:** Conducted secondary research on best practices for approval processes in other sectors (e.g., Federal Strategic Environmental Research and Development Program; EMA Conditional Marketing Approval) to spur ideas for potential adjustments to the MHSA Innovation approval process.
- **Discussion group:** Facilitated four meetings with a 16-member focus group composed of individuals who are engaged with different parts of the Innovation system (including

stakeholder advocates, consumers, family members, behavioral health directors, MHSA Coordinators, other state leaders, and MHSOAC leadership) focused on potential solutions and recommendations to improve MHSA Innovation through a cross-sectoral lens.

- **Focus groups (MHSOAC staff):** Facilitated three focus groups with between one and three participants of MHSOAC staff to gauge feedback on the resource library & recommendations.
- **Focus groups (MHSA Coordinators):** Facilitated three focus groups with between one and four MHSA Coordinators to gauge feedback on the resource library & recommendations.
- **Focus groups (community engagement):** Coordinated with CAMHPRO and NAMI California to facilitate three focus groups with over 20 members to gather input on a starter community engagement resource focusing on authentic engagement of community members.
- **Subcommittee on Innovation meetings:** Presented at two Subcommittee on Innovation meetings to gather feedback from Commissioners and meeting attendees.
- **Commission meetings:** Joined most Commission and many Subcommittee meetings and incorporated insights from presentations and comments.

Recommendation 1. Supplement the definition of innovation with further guidelines

During our project's barrier interviews, County leaders expressed a lack of clarity in interpreting the laws governing how MHSA Innovation funds can be spent, including what qualifies a project as innovative. We have also seen this play out for other members of the Innovation community, both in Commissioner questioning during approval discussions and through public comments. To clarify this uncertainty, we recommend that the MHSOAC puts forward accessible, plain-language guidance to support understanding of how to meet requirements, and what types of projects qualify as innovative.

We recommend that this guidance take the form of two resources: (1a) an FAQ resource that directly addresses common areas of uncertainty and (1b) a list of types of project examples that would and would not qualify as innovative. Many interviewees commented on the importance of providing guidance without being overly restrictive as to how innovation can be interpreted, and we have carefully considered that perspective within the recommendations below.

1a. Create an Innovation FAQ resource to clarify areas of ongoing uncertainty

This Innovation FAQ resource would address specific areas of uncertainty expressed by members of the Innovation community—while, at the same time, attempting to reinforce core aspects of the Innovation Component of the MHSA (e.g., the centrality of learning). The resource could serve as the main landing page about Innovation on the MHSOAC website and be printed and distributed at relevant Commission Meetings. We recommend that the resource:

- **Include a brief (two- to three-sentence) statement explaining what Innovation is and how funds are intended to be used.** Throughout interviews, members of the Innovation community shared differing views on the intended purpose of Innovation. For example, some interviewees believed that Innovation Projects need to be technology focused, while others believed that Innovation Projects are "ideas that had never been done anywhere in the world before." We recommend that any updated description of Innovation align as closely as possible with how Innovation is described in the MHSA, take into account observations and patterns gleaned from the years of experience the MHSOAC has with overseeing Innovation, and remain broad enough to encompass creative ideas that could meet the needs of diverse communities throughout California.

  We also suggest that this new description emphasize Innovation's potential to facilitate *learning*, which was the most frequently cited definition of Innovation we heard among interviewees. To elevate the importance of this new description, we recommend presenting it to Commissioners during a Commission meeting.

- **Give an overview of the laws governing Innovation.** Interviewees expressed confusion around what legal requirements Innovation Projects must meet (e.g., 9 CCR § 3910; 2016 amendment to WIC § 5830). The FAQ resource should gather all of the requirements in one place, including a brief explanation of how the laws governing Innovation were developed and changed over time (written in language that doesn't require a legal background to understand).

- **Provide answers to frequently asked questions** about the interpretation and governance of Innovation requirements not covered in the above. In ***Figure 1*** below, we have included a starter list of questions that we heard in interviews, alongside sample answers.

FIGURE 1. Starter list of FAQs and sample answers about Innovation requirements

What are some reasons an Innovation Plan would not be approved by the Commission?	Innovation Plans must meet several requirements in order to be approved by the Commission. Reasons an Innovation Plan might not be approved include: • The mental health practice or approach included in the Plan has already been sufficiently tested within the population or context proposed • The evaluation plan for the project does not help assess the impact of the proposed Plan in a way that helps the County shape future mental health initiatives • It is unclear how the Plan reflects community priorities and need
How is "new" defined in the context of MHSA Innovation? (I.e., is "new" in relation to my county, the state, the country, the world?)	An Innovative project must: • Propose a ***new*** approach to the overall mental health system; • ***Adapt*** an existing approach used elsewhere (which includes applying that approach to a different population, setting, or community); or • ***Adopt*** a promising community-driven approach that has been successful in non-mental health contexts.[1] If an approach is ***adapted***, the County has to provide documentation about how and why the County is adapting the practice or approach.
If a proposed Project does not introduce a new approach, but adapts or adopts an existing approach, what magnitude of change or adjustment is needed to qualify as innovative?	Because Innovation Projects vary so widely in scope, it is impossible to provide a general rule about the level of change that would qualify a project as innovative. However, Counties must provide documentation about how and why the County is adapting the practice or approach. For example, the change can include an adaptation for a rural setting of a mental health practice that has demonstrated its effectiveness in an urban setting.
Do Innovation Projects have to include service delivery? Do they have to include technology?	No and no. The requirements for Innovation are open-ended and can impact many different aspects of the mental health system, such as: • Administrative, governance, and organizational practices, processes, or procedures

[1] Language borrowed from ACCESS California's *Overview of Innovation Components*: https://272d6681-17ea-42d0-9bbc-bc096b89055a.filesusr.com/ugd/c82a51_9f04eea3ccae4de0b1198af63b070e8b.pdf.

	• Advocacy • Education and training for service providers, including nontraditional mental health practitioners • Outreach, capacity building, and community development • System development • Public education efforts • Research • Services and interventions
What are the requirements for community input into Innovation Projects?	Community input should be incorporated in all aspects of planning, from idea generation to prioritization to evaluation design. Successful Innovation Plans emerge from a clear understanding of community needs, authentic engagement about how to best serve those needs, and an ongoing dialogue about what we're learning from new approaches.
As a consequence of the 2016 amendment to section 5830 of the Welfare and Institutions Code, are all Plans that directly address permanent supportive housing (PSH) automatically considered Innovative?	Yes. Innovation Plans that directly address increasing access to services through PSH are seen as *equally* favorable compared to plans that address the other General Requirements. The MHSOAC would consider a Plan that addresses services through PSH as innovative.

NEXT STEPS

As part of this project's resource library, we will adapt the above list of questions above into a draft FAQ resource. We suggest that the MHSOAC team update the draft based on their own experiences with common questions they hear about Innovation, and then gather feedback from the Innovation community to determine whether the responses sufficiently clarify their questions. Finally, to ensure this resource continues to stay relevant and useful, the MHSOAC should periodically update the list of questions as new ones arise.

1b. Develop a sample list of types of projects that would qualify as "innovative"

To supplement the FAQ resource, we recommend that the MHSOAC develop and make publicly available a non-exhaustive list of example projects that ***would*** and ***would not*** qualify as innovative. The list could be based on historical Innovation Projects and hypothetical Innovation Projects that the Commission would approve (assuming all other aspects meet the Plan requirements).

As a starting point, we have included some ideas in ***Figure 2.*** This list was developed based on a review of past Innovation projects that were approved, and our understanding of types of projects that are typically not approved based on feedback from the Innovation community.

FIGURE 2: Starter list of types of projects that would and would not qualify as innovative

What innovation is…	What innovation is not…
• Creating a team that improves enrollment of LGBTQ+ seniors into higher levels of PSH case management through community ambassadors	• Expanding an existing substance use treatment program for LGBTQ+ seniors offered by the County by engaging a different provider
• Introducing a new-to-county school-based therapy program with the purpose of increasing the quality of mental health services delivered in schools	• Re-starting a successful school-based therapy program that was previously discontinued in the County
• Adopting a community-driven practice that has been successful in non-mental health contexts, with a clear plan to measure and understand how the County adopting the practice will increase accessed to underserved groups[2]	• Adopting a community-driven practice without a plan or goal for measuring or understanding the extent to which that practice makes progress against the Plan's chosen primary purpose[3]

NEXT STEPS

As part of this project's resource library, we will expand on the first draft of the above list. As with the FAQ resource, we recommend that MHSOAC staff work with Commissioners and other members of the Innovation community to further develop the list and to create a process for periodically updating it over time.

A version of this resource could also be used by Counties to support community training required by 9 CCR § 3300(c)(3) as part of the CPP process.

[2] "Underserved groups" as defined in 9 CCR § 3200.300

[3] Primary purposes are defined in 9 CCR § 3910(c)

Recommendation 2. Expand and deepen technical assistance to Counties

Innovation Projects require insights and proficiency across an array of domains. Several County leaders told us they do not have enough in-house capacity to develop, implement, and evaluate transformational Innovation efforts within the timelines and parameters required by the MHSA. This challenge is compounded for smaller Counties, where one staff member may be covering facets of public mental health that larger Counties may have teams or departments for.

The two sub-recommendations profiled below—(2a) strengthening support functions to meet County needs and (2b) forming an Innovation Support Group—are designed to help bridge the learning gap as Counties conceptualize and develop Innovation Plans and Projects with their communities.

2a. Strengthen support functions to meet County needs

Currently, the MHSOAC offers technical assistance to Counties, including through learning collaboratives, the Innovation Incubator, site visits, and staff assistance on Innovation Plans. This technical assistance was highly regarded among interviewees, and Counties expressed desire both for additional capacity for the technical assistance currently offered (i.e., adding members to the MHSOAC staff Innovation Team), and expansion into further topic areas that, while optional, will help Counties achieve transformational change. These topic areas included:

- **Community engagement:** Engaging local community (through the CPP process and otherwise) is one of the most difficult yet important requirements of developing an Innovation Plan. In many counties, there is real engagement and authentic partnership with consumers and family members across a diverse set of populations (e.g., immigrants and refugees, transition-age youth, veterans, LGBTQ+, racial and ethnic minorities). Still, other counties have less-robust practices, and may benefit from additional resources to help strengthen their efforts. We also heard from County leaders that while many innovative ideas existed within their communities, they do not always align with Innovation funding requirements. Therefore, technical assistance should not only focus on robust community engagement, but how to shape ideas from the community into projects that can be funded by Innovation dollars (e.g., by employing techniques such as human-centered design).
- **Evaluation:** Seventy-five percent of the MHSA Coordinators we surveyed responded that receiving evaluation training, technical assistance, and support would be 'extremely' or 'very useful' for developing Innovation Plans and implementing projects (n=55). Evaluation requires significant technical training to design methods that appropriately measure impact; determine whether that impact is meaningful; and to access, clean, verify, and use reliable data sources to measure progress. Not all Counties have this capacity in-house, and contract with external evaluators for Innovation Projects. However, evaluator procurement typically occurs *after* Innovation Plans and budgets are written and approved, meaning that evaluation experts are not always present during critical planning periods. Therefore, we recommend that any increased technical assistance around evaluation focus on the planning period, setting Counties up for success to be able to track, evaluate, and learn from Innovation Projects after launch.

- **Sustainability planning:** We heard from County leaders that it is often difficult to identify and secure funding sources to sustain Innovation Projects. Deeper discussions, via focus groups, suggest that this is a multifaceted challenge: in part, it's driven by underpowered evaluations (see above), and in part by a lack of focused sustainability planning (in the form of careful performance management, cost analysis, and collaborative governance). Technical assistance around sustainability planning would focus on (1) using evaluation results and client/provider feedback to determine which components (if any) of an Innovation Project should be sustained at project end, and (2) identifying strategies to secure a funding source to sustain those components while minimizing disruption for participants.

In addition to the topics listed above, the MHSOAC could also conduct an ongoing survey of County staff to help determine specific areas of technical assistance that Counties would be particularly eager for alongside areas they feel fully supported by already.

Increased technical assistance should also be supplemented through the dissemination of static resources. We heard repeatedly that Counties ask one another for practical resources (e.g., language for flyers, descriptions of the Innovation Component, evaluation resources); informally, MHSA Coordinators "know who to ask" for different kinds of materials, resources, and ideas. This kind of informal sharing is invaluable, but it can also leave out less-tenured Coordinators, who report feeling overwhelmed by the number of resources available and yet sometimes unable to find the right ones. With that in mind, we see value in formalizing "hotline" support from MHSOAC staff (or partners) to manage thoughtful curation of resources and help Counties find those that will be most helpful and appropriate for their situation.

Additionally, the resources would build on the MHSOAC's ongoing efforts to summarize and clarify the different components of the MHSA (e.g., the upcoming MHSA Overview PowerPoint). Details on the Innovation Component in a resource like the PowerPoint could be used for onboarding for County leaders, County Boards of Supervisors, local mental and behavioral health boards and commissions, and members of the public with an interest in Innovation.

NEXT STEPS

The primary next step is to determine the ideal scale of enhanced technical assistance and the level of resources required to implement it. To do this, we recommend building upon the survey results we collected from MHSA Coordinators about potential resources for developing and implementing Innovation Projects,[4] working with the CBHDA to further specify topics of interest and gauge member capacity to engage in increased technical assistance. While aimed at enhancing local capacity, technical assistance relies on County staff availability; therefore, to build net capacity, technical assistance must provide differentially more value than the cost of staff engagement.

Based on the MHSOAC's thin staffing model, additional funding from the legislature will be required. Our MHSA Coordinator survey suggests substantial further need.

Lastly, as part of this project's resource library, we are collaborating with project partners and other members of the Innovation ecosystem to collect resources (and, at times, either develop a draft of, or

[4] See Appendix 4 for full survey results.

propose approaches for developing, new resources). We aim to complete these efforts in the coming months and view them as a starting point for the dissemination of resources described above.

2b. Form an "Innovation Support Group" to provide input and perspectives for each Innovation Plan

Some Counties have deeply engaged stakeholder groups, with diverse expertise, who are available to help them pressure-test ideas for Innovation plans. To formalize this support and ensure it is available to all counties, the MHSOAC (or another relevant organization such as California Mental Health Services Authority [CalMHSA] or CBHDA) could develop a support group to serve as advisors on specific aspects of plan development. Under this mechanism, the organizers would facilitate a rotating group (the "*Innovation Support Group"*) to provide optional input on potential Innovation plans. The group would listen to Counties informally share about an Innovation Plan they are working on and collaborate to provide perspectives, guidance, and questions in about how to further develop the Plan, drawing from the discussion guide described in Recommendation 3c.

Innovation Support Group members should have an in-depth understanding of the Innovation Component, and should be knowledgeable about characteristics of Counties of different sizes (including rural and frontier Counties) as well as other unique County characteristics that reflect California's diversity. We see the potential composition of the Innovation Support Group as including:

- One representative from the Client and Family Leadership Committee (CFLC)
- One representative of the Cultural and Linguistic Competency Committee (CLCC)
- One representative from the Research and Evaluation Committee
- One representative of an organization that holds a Stakeholder Advocacy Contract with the MHSOAC (if the Plan aims to serve a specific population, ideally, the corresponding contract holder would join the Support Team for that Plan)
- One representative from the Youth Innovation Project Planning Committee
- One representative from the MHSOAC staff Innovation Team
- One representative from the MHSOAC staff stakeholder engagement and grants team
- One member with expertise in public and community engagement
- One member with current or past experience working in an MHSA-related role at a County

We believe that the Innovation Support Group would benefit Counties by providing them with (optional) actionable feedback and additional points of view on Plans before they are voted on for approval. Having input from the group may also aid Counties in completing hearings with their local mental and behavioral health boards and commissions and seeking local Board of Supervisor approval, as well as strengthening the Plan's credibility in front of Commissioners.

Given the present volume of Innovation Plans submitted to the Commission for approval, we would recommend holding monthly, two-hour long Innovation Support Group meetings and meeting with three Counties per meeting. We also expect that that this cadence may need to be adjusted over time, depending on County interest.

The time required to attend monthly meetings, combined with the relatively steep learning curve required to understand how the Innovation funding stream works, means that serving on the Innovation Support Group would be a significant commitment. If the MHSOAC decides to implement this recommendation, they should consider ways to lessen the burden on participants, including offering compensation where appropriate and offering training on the intricacies of the Innovation Component (more discussion in 'Next Steps' below).

NEXT STEPS

We recommend the following next steps if the MHSOAC decides to adopt this mechanism:

- Hold **focus groups with Counties** (potentially in collaboration with the CBHDA) to discuss and understand the appropriate level of detail and timing for sharing a plan with the Innovation Support Group and which organization is most appropriate to host the group (e.g., the MHSOAC, CBHDA, CalMHSA, others). As part of these focus groups, the MHSOAC should also seek to understand how an Innovation Support Group can help to improve Innovation Plan development, rather than simply add to process.
- Conduct a **series of interviews with potential Innovation Support Group members** to (1) understand what level of training, compensation, and/or other resources they would need to be successful as a support group member and (2) obtain their input on support group design.
- Consider whether the Innovation Support Group will require **additional resources** (e.g., staff time, compensation for participants), and how those resources will be funded.

Recommendation 3. Further clarify expectations for Plan development

Counties have expressed uncertainty regarding what is expected in Innovation Plans, the relative importance of different Plan components, and what Commissioners will focus on when reviewing Plans. To address this uncertainty, we recommend (3a) making revisions to an existing tool (the Innovation Project Plan Recommended Template) and (3b) developing a new tool (an Innovation discussion guide), each aimed at guiding various partners through the Innovation Plan development, review, and approval process. A summary of the current state and recommended changes for tools used to review Innovation plans is in **Figure 3** *below.*

As another strategy to clarify expectations for Plan development, we recommend that the MHSOAC develop target dates for Counties to submit Plans (Recommendation 3c). The goal of these target dates would be to encourage Counties to submit Plans far in advance of reversion, allowing for enough time for technical assistance from the MHSOAC, and deescalating "do-or-die" last-minute approvals.

FIGURE 3. Overview of plan review tools

	Innovation Project Plan Recommended Template	MHSOAC Staff Analysis	Innovation Discussion Guide
Current Status	Used by Counties when writing plans	Used by MHSOAC staff for all County plans	Proposed; not yet developed
Purpose	Provides consistent and clear framework for **Counties to develop** and write Innovation Plans	Provides consistent template for the MHSOAC staff **Innovation Team to analyze** and summarize County plans	Could provide consistent structure for **Commissioners to assess** Innovation plans
Barriers to Address	Some duplication in template sections, confusing budget template	Inexplicit connections to Recommended Template; significant time burden on the MHSOAC staff Innovation Team	Commissioner review has limited structure, making it difficult for Counties to understand what Commissioners look for
Recommended Change	Simplify the Innovative Project Plan Recommended Template (discussed in 3a)	Ensure continuity between the Innovative Project Plan Recommended Template, the Staff Analysis, and any discussion guide	Create a discussion guide for the Commission and others to use when assessing plans (discussed in 3c)

3a. Simplify the Innovative Project Plan Recommended Template by orienting the template around key questions

To simplify the Recommended Template, we recommend reorienting the template around a short set of simple questions that allow Commissioners, MHSOAC staff, and others to understand the most important elements of a Plan. These questions were first developed by MHSOAC staff for their analysis of Innovation Plans and include:

- What is the **problem or challenge** the Plan seeks to address?
- What is the **innovation**?
- How will the Plan include **community collaboration**?
- How will the Plan be **implemented** (including the **budget** to do so)?
- What will we **learn** from the Plan, and how will it be **evaluated** to ensure that this learning is captured?

We have started reorienting the template around these questions by reviewing the Innovation Regulations and reorganizing them into a new proposed structure that follows the flow of the questions in ***Figure 4***. The proposed restructured template highlights measures of community engagement in each step of the process to reflect the importance of community feedback throughout.

NEXT STEPS

We will build upon ***Figure 4*** and develop a mock-up of the reorganized template to include as part of this project's resource library. In doing so, we will work to ensure that the template is conducive to Multi-County Collaboratives and for projects with a focus other than service delivery, as we heard this can be a challenge with the current template. We recommend that the MHSOAC pilot the new template with a small number of Counties to gather feedback and make any relevant adjustments before putting the template to broader use. It may also be helpful to provide example plans focused on different primary purposes and learning goals.

FIGURE 4. New proposed structure of Recommended Template

Section	Sub-Section	Relevant Regulation(s)
What is the problem or challenge the Plan seeks to address?	What is the persistent mental health challenge this Plan addresses?	3910(d)
	Describe how the County identified this challenge via the CPP process.	3930(a)
	How did the County ensure that staff and stakeholders involved in the CPP process were informed about the purpose and requirements of the MHSA?	3930(b)(1)
	Why is there a need to innovate to solve this challenge, instead of using an approach with demonstrated effectiveness?	3930(c)(2)

What is the innovation?	Does this Plan seek to address the challenges described above by: (1) introducing a new approach, (2) making a change to an existing approach (including application to a different population), (3) adopting a promising community-driven practice or approach that has been successful in non-mental health contexts, or (4) supporting participation in a supportive housing program?	3930(c)(3)
	Describe the new or changed mental health approach proposed in the Plan. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.	3930(c)(4)
	What is the primary purpose (or goal) of introducing this innovation? *[list options]*	3930(c)(2)
How will the Plan include community collaboration?	Briefly describe, using specific examples, how this Project will reflect the MHSA General Standards (community collaboration; cultural competence; client-driven; family-driven; wellness, recovery, and resilience-focused; integrated service experience for clients and their families).	3930(c)(4)(d)
How will the plan be implemented (including the budget to do so)?	Include a project timeline that shows the overall project duration and milestones for: • Development and refinement of the approach • Ongoing assessment and final evaluation • Decision-making about whether and how to continue a successful Innovative Project or parts of the project • Communication of the results and lessons learned	3930(c)(8)(A) and (B) 3930(c)(3)(A)
	[if applicable] Describe the population to be served by the Project, including demographic information and estimated number of clients to be served annually.	3930(c)(4)(B) and (C)
	How will the County decide whether to continue the Innovation Project, or elements of the project?	3930(c)(6)
	How will the County involve community stakeholders meaningfully during Project implementation, including in decision-making about whether to continue the Project after this Plan is finished?	3930(b)(2)
	[if applicable] How does the County plan to protect and provide continuity of service for clients after the project ends?	3930(c)(7)
	Budget narrative	3930(d)

What will we learn from the plan, and how will it be evaluated to ensure that this learning is captured?	What method will the County use to evaluate the effectiveness of the plan? *Please include: intended outcomes, how those outcomes will be measured, and specific indicators for each intended outcome*	3930(c)(5)
	How will the County involve community stakeholders meaningfully in project evaluation?	3930(b)(2)
	How do you expect the Project will contribute to the development and evaluation of a new or changed practice in the mental health field?	3930(c)(3)(B)

3b. Create a discussion guide for Commissioners and others to use when assessing plans

During interviews, County leaders reflected uncertainty around what Commissioners will focus on when reviewing and approving Innovation Plans. To address this challenge, we recommend that the MHSOAC develop a discussion guide that can be used by Commissioners to assess and provide structured feedback on Innovation Plans during Commission meetings. (This guide would tie in closely with the Innovative Project Plan Recommended Template and Staff Analysis, weaving a common thread across the three tools.)

As part of our project's focus groups and during the Subcommittee on Innovation meeting in late April 2021,[5] we solicited feedback and input on this guide as a potential review tool to demystify the Commissioner approval process. These discussions surfaced various perspectives about the benefits and challenges of implementing such a tool; a high-level summary of which is in ***Figure 5***.

FIGURE 5: Potential benefits and challenges of a discussion guide

Benefits: Potential ways an Innovation discussion guide could improve the Innovation Component	**Challenges:** Potential challenges of implementing an Innovation discussion guide
• Provides insight for County presenters into what Commissioners will focus on when discussing Plans • Assists Commissioners in their preparations for reviewing Innovation Plans and in guiding their questions of presenters • Having a consistent structure for Plan review could make Commission meetings easier to follow for the public	• Innovation is inherently challenging to define; reviewing Innovations with a template may prove counterproductive • Any kind of scoring mechanism or rubric may be overly prescriptive, limiting the autonomy and flexibility of Commissioners • Too much structure and a clear path to approval could discourage Counties from "thinking outside the box"

[5] Meeting Summary: https://mhsoac.ca.gov/sites/default/files/INN%20Subcommittee_Teleconference%20Summary_4.28.2021_Final.pdf.

Our discussion also focused on different ways this tool could be operationalized, including whether the guide should be quantitative (score-based) or qualitative (discussion-based). While a quantitative guide would provide more clarity about Commission priorities, Innovation Plans vary widely in scope; it may put unnecessary constraints on innovation to build a "one size fits all" approach to scoring any Plan that comes before the Commission. Therefore, we recommend that the guide be discussion-based rather than score-based.

Lastly, we discussed what questions could be included in the tool. Based on those conversations, a starter list of questions is in ***Figure* 6** below, although should the MHSOAC decide to adopt this tool, more input is needed from members of the Innovation community (e.g., Commissioners, the public, MHSOAC subcommittees, stakeholder advocates) on what the questions should be.

FIGURE 6: Starter list of questions to include in the discussion guide

Topic	Questions
Problem/ Challenge	• *What challenges does the Plan address, and how were those challenges identified?* • *How were community members engaged in defining the problem being addressed and identifying potential solutions?*
Innovation	• *What makes this Plan innovative? How is it different from the status quo in the County?* • *If applicable, what other innovations were considered, and why was this one chosen?*
Community Engagement	• *How were unserved and/or underserved populations included in the larger CPP process and in Plan development? How were any specific populations the Plan aims to serve included in the development of the project, and in implementation / quality improvement moving forward?* • *What training was provided to community members who participated in the CPP process?*
Implementation	• *Who is the County planning to partner with to implement this Project (technical assistance providers, community-based organizations, service providers, other government agencies)?* • *How will the innovation approach be adapted and refined throughout the Project?* • *How might this Project (or parts of the Project) be sustained in the future?*
Learning	• *What learnings will the Project contribute to the County and/or to the mental health field?* • *To what extent will the evaluation methods in the Plan give us reliable information about the project's impact and learning goals?* • *How do the outcome metrics being evaluated reflect priorities of the people being served by the Project?*

NEXT STEPS

As a next step, we will build on the starter list of questions in ***Figure 7*** to include in this project's resource library. Then, we recommend that MHSOAC:

- Gather **feedback from Commissioners** on their support of an Innovation discussion guide, holding one-on-one meetings to understand if the tool would be helpful for discussion and approval of Innovation plans.
- **Develop a simple pilot implementation plan,** including recommendations for how Commissioners should use the guide (considering any adjustments to the approval process based on Recommendation 5 in this report).
- **Review the questions** in the draft discussion guide included in this project's resource library and **gather feedback** on the questions from members of the Innovation community (including via public comment).
- **Pilot the discussion guide** during a Commission meeting; **revise and implement** based on the pilot.

3c. Develop target dates for submitting Plan concepts and drafts to MHSOAC staff

Some Counties have not been able to use Innovation funding in the timeframes required by the MHSA, putting funds at risk of reversion. Relatedly, many Plans are submitted to the MHSOAC close to the reversion deadline, creating a backlog at the end of the fiscal year, which can negatively impact Commission workload and result in Plans that are "rushed" over the finish line.[6] To help mitigate this, the MHSOAC could develop a set of recommended target dates for plan submission far in advance of reversion, leaving ample time for MHSOAC staff to provide technical assistance and for Counties to make revisions. The target dates would be based on forecasting available Innovation funds for each county, divided into three categories:

- Funds at risk of reversion in the current or next fiscal year
- Cash on hand available for Innovation Projects
- Funding that can reasonably be expected three to five years in the future[7]

Counties would not be required to follow the target deadlines; they would simply serve as additional guidance to help mitigate the reversion and backlog challenges during what can be an extensive planning process. They could also serve as a mechanism for increasing communication between MHSOAC staff and Counties throughout the fiscal year about funds at risk of reversion.

NEXT STEPS

The next step of this recommendation is for the MHSOAC to review DHCS forecasts of available funds by County, divided into the three categories listed above. MHSOAC staff should then estimate appropriate target dates for planning milestones in each category based on the amount of time it typically takes to

[6] For example, in FY2019-20, the Commission reviewed 16 Innovation Plans in the final two months of the fiscal year, after receiving only 11 plans in the first 10 months of that year.

[7] This analysis builds on the Staff Memo "Supporting County Innovation." https://mhsoac.ca.gov/sites/default/files/Innovation%20subcommittee%20memo%20final%2010292020_0.pdf

develop and review an Innovation Plan, working backwards from approval to initial planning. This estimation should consider whether it makes to stagger target dates by County size; larger Counties with more staff dedicated to Innovation and higher Innovation allocations tend to submit Plans at a higher frequency than smaller Counties.

The CBHDA and/or individual Counties could then review the proposed dates to ensure they reasonably align with historical timelines to develop an Innovation Plan.

Recommendation 4. Develop mechanisms to accelerate the diffusion of learnings from Innovation Projects

Members of the Innovation community expressed that Innovation Project learnings rarely make their way across County lines, limiting the opportunity for learning and replication/adaptation by other Counties. Interviewees expressed a desire for more and better ways to share lessons across Innovation Projects throughout the project life cycle. Moreover, improving the culture of shared learning can help normalize the idea that failures are acceptable—indeed, inevitable—for Innovation Projects.

To address this challenge, we recommend three strategies to share learnings across Counties:

(4a) Publish case studies of stand-out practices and processes Counties have used to design and implement Innovation Plans

(4b) Host an annual Innovation convening for MHSA Coordinators and other County leaders

(4c) Create a database of Innovation Projects and learnings

(4d) Require Counties to present outcomes and findings at Commission meetings

4a. Publish case studies of stand-out practices and processes Counties have used to design and implement Innovation Plans

To increase peer-to-peer learning, the MHSOAC could publish case studies that showcase practices and processes used during Innovation Projects that could be useful to other Counties when developing and implementing their own Projects. We envision these case studies as short, 2- to 4-page documents that provide an overview of the practice and/or process, a summary of lessons learned, and contact information to learn more. They should provide just enough information to help a County leader understand if they would be interested having a phone call to learn more about the highlighted practice/process for use in their own County, and should not be burdensome for County leaders with Projects selected for dissemination.

Case study topics should focus on areas most relevant and interesting to Counties—for example, community engagement, planning grants, evaluation strategies, and sustainability. As a starting point, we are developing five case studies that focus on these areas (to be included in the resource library). Continued authorship of these case studies could include MHSOAC staff, the CBHDA, or Counties themselves (using a template for consistency).

FIGURE 7: Examples of case studies to be included in this project's resource library[8]

Title	County	Topic
BeHealth.Today Program: Using Human-Centered Design to Uplift Innovative Ideas	San Diego	How partners in San Diego County used an Innovation planning grant to fund a **human-centered design process** consisting of working with people with lived experience and community groups to create new proposals for Innovation
The Interdisciplinary Collaboration and Cultural Transformation Model: Community Driven Quality Improvement Plans	Solano	How partners in Solano County developed 14 community-driven **Quality Improvement Action Plans**[9] focused on increasing culturally and linguistically responsive mental health services to improve the experiences and mental health needs of three underserved communities in the County
Understanding the Mental Health Needs of the American Canyon Filipino Community: Identifying Youth Needs Through School Partnerships	Napa	How partners in Napa County launched an Innovation Project in **local schools** aimed at understanding the needs of an underserved population identified using **school district data**

NEXT STEPS

As a next step, the MHSOAC should develop a process for creating additional case studies including:

- Determining which organization(s) have interest and/or capacity for **authoring future case studies** (e.g., MHSOAC staff, the CBHDA, Counties themselves, or some other external partner)
- Deciding how to **identify and select** Projects from varying Counties that might be a good fit for a case study (e.g., via County nomination, MHSOAC staff Innovation Team selection, or a group of individuals from across the Innovation community)
- Planning for **case study dissemination** via the MHSOAC website (tracking downloads to understand which case studies are read most frequently), Innovation Boot Camps, CBHDA meetings, and any relevant other multi-county forums

4b. Host an annual Innovation convening for MHSA Coordinators (and other County leaders)

Throughout our listening tour for this project, County leaders repeatedly expressed gratitude for opportunities to learn from one another in both formal and informal settings. While they largely acknowledged difficulty finding time for the many competing priorities in their day-to-day work, 76

[8] Two additional case studies in progress (exact titles and topics TBD), for a total of five case studies.
[9] Quality Improvement Action Plans are a set of recommendations that focus on systematic and continuous actions that lead to measurable improvement in mental health services and the health status of priority patient groups.

percent of the MHSA Coordinators we surveyed said that "an annual convening of MHSA Coordinators, BHDs, and others to share learnings across Innovation Projects" would be an "extremely" or "very" useful resource for developing Innovation Plans and implementing projects.[10]

Topics in a convening could mirror those raised by County leaders as being most helpful in an expanded technical assistance function discussed in Recommendation 2a: community engagement, evaluation, and sustainability planning. The case studies discussed in Recommendation 4a could also serve as a foundation for programming at a convening of County leaders and other members of the Innovation ecosystem, with profiled Counties reporting out on their respective approaches, questions and answers, and less-structured brainstorming on further opportunities to collaborate.

A convening could also serve as a forum for (1) training associated with the expanded technical assistance function discussed in Recommendation 2a and (2) County leaders to read out lessons learned from Innovation Projects that are concluding (see Recommendation 4d). It could also serve as an informal feedback mechanism for the MHSOAC, particularly if staff are able to observe sessions and identify patterns they are seeing in the types of questions and ideas that arise.

A primary limitation for an annual convening is cost, both to the MHSOAC for administrative and venue costs, and to participants, who will likely travel to the event (though a virtual option could also be built into the convening design) and spend time engaging in sessions. Strategies to reduce costs for participants could include:

- Rotating the conference's location to enable participation from a broader segment of the Innovation community. The MHSOAC could also consider holding multiple regional convenings instead of one state-wide conference, although this would likely increase costs.
- Leveraging existing conferences and events, such as those held by Words to Deeds, the CBHDA (e.g., Innovation Boot Camps), and the California Institute for Behavioral Health Solutions (CIBHS), by holding Innovation meet-ups and generating support and participation in the Innovation convening.
- Ensuring a low barrier to entry for County leaders and anyone else invited to the meeting by scheduling it far in advance, minimizing the amount of "pre-work" asked of participants, and creating clear programming choices so participants do not get become overwhelmed by the volume of options.

The first convening will help generate momentum and serve as a proof of concept for further convenings. (If participants do not deem it useful, they may be unlikely to participate in the future.) With this in mind, co-designing the programming through a survey of potential participants will be valuable.

NEXT STEPS

To advance this idea, the MHSOAC would need to identify funding for the convening, including staff time, venue fees, speaker fees, refreshments, and other logistical items (e.g., a/v equipment, support staff at "check in," signage). With funding secured, the MHSOAC could identify a staff member to

[10] Full survey results in Appendix 4.

organize the event, likely starting with a survey of County leaders on what discussion items will be most beneficial.

4c. Create a database of Innovation Projects with qualitative and quantitative Project outcomes, information about the Project's population of focus, and other important elements of the Project

To support the centricity of learning in the Innovation component, the MHSOAC could build out a catalog of launched Innovation Projects with detailed information about each. Interviewees have expressed that while the Transparency Suite on the MHSOAC website has provided a helpful preview of Innovation Projects, there is appetite for additional information, especially about lessons learned for each project. ***Figure 8*** includes a list of potential fields for the expanded database. To facilitate information gathering for the database, the MHSOAC could consider publishing recommended templates for the Final Innovative Project Report that includes a section that aligns with the fields in the database.

FIGURE 8: Data fields for an expanded database of Innovation Projects

Category	Potential Fields
Project Information	Project duration; total funding amount; start and end dates; whether the project was part of a Multi-County Collaborative or the Innovation Incubator
Innovative Project General Requirements	Whether the Plan approach is new, adapted, or adopted; the Plan's Primary Purpose
Project Overview	Brief description of project; link to the original Innovation Plan
County Information	County name; relative size (small, medium, large); geography (urban, suburban, rural); threshold languages; demographics
Population Served	Racial, ethnic, and cultural groups; LGBTQ+ populations; age groups (transition-age youth, seniors); immigrants and refugees; veterans; people experiencing homeless; people with SMIs; family members; people with disabilities; whether the population is one of the five priority populations implementing the CRDP
Evaluation	Type of evaluation; evaluator name; evaluation budget
Project Outcomes	List of outcomes from the project's evaluation
Project Learnings	Qualitative description of lessons learned including feedback from project participants, programmatic learnings for Counties, and how these learnings can inform future practices (in the form of open-ended comments with a character limit)
Project Reports	Links to the Final Innovative Project Report and Annual Innovative Project Reports
Funding Sustainability	Ongoing funding stream if the project (or part of the project) was sustained

NEXT STEPS

If the MHSOAC decides to adopt this recommendation, the next steps are to (1) gather feedback from the Innovation community to determine which metrics should be added to or adjusted from the above list and (2) determine whether the revised database should include all past Innovation Projects, or be forward-looking only. With that information, the MHSOAC can estimate the level of resources required to build the database and add it the website as part of the Transparency Suite, and whether additional resources (e.g., a database contractor) would be necessary to do so.

4d. Require Counties to present concise outcomes and findings summaries at Commission meetings by adding Project readouts to the meeting agenda at the conclusion of each Innovation Project

We heard from many members of the Innovation community (including Commissioners) that Commission meetings focus too much on approval and not enough on learning. To mitigate this, the MHSOAC could require Counties to conduct five-minute presentations at Commission meetings each time they submit a Final Innovative Project Report, focusing on what they learned and how those learnings could contribute to field. Final Innovative Project Reports should also be included in Commission meeting materials for review by Commissioners and the public, as well as sent to the CBHDA to disseminate to its members.

If Commission agenda time for sharing Project learnings is difficult to find, MHSOAC staff should summarize key findings and outcomes to be included in Commission meeting materials. Over time and with a more streamlined Innovation Plan approval process, such a summary could be replaced by short presentations from the Counties themselves.

NEXT STEPS

To advance this idea, the MHSOAC would need to estimate the total amount of time Project readouts would take (based on the number of expected completed projects per year), whether it would be feasible to add that amount of time to the current Commission meeting schedule, and if not, if there are other agenda items that could be deprioritized in favor of sharing Project learnings. Notably, the sharing of Project learnings should not come at the expense of Counties being able to schedule Innovation Plans for approval on Commission meeting agendas when needed.

Recommendation 5. Test a multi-stage approval process that provides concept approval earlier in the Plan development cycle

When Innovation Plans are developed, Counties receive feedback over several months from many different individuals and organizations (including community members, local mental and behavioral health boards and commissions, OAC staff). However, Commissioners do not weigh in until much later in the process: typically, their first view into an Innovation Plan occurs when they receive the completed Plan accompanied by MHSOAC Staff Analysis approximately 10 days before voting on the Plan's approval (see **Figure 9** *below). This leads to several challenges:*

- *It is difficult for Commissioners to give significant or meaningful feedback on the direction an Innovation Plan while simultaneously voting on its approval*
- *Counties receive no direct feedback from Commissioners about whether a Plan is "on the right track" until months of time and resources (including significant community input) have been spent developing the Plan—despite the ambiguous nature of Innovation*
- *It puts unnecessary pressure on a single meeting, incentivizing Counties to build Plans around "what they think the Commissioners want to hear" and incentivizing Commissioners to vote to approve Plans even if they are on the fence.*

Establishing a multi-stage approval process that provides "concept approval" (described below) could help counteract some of these challenges.

Under a multi-stage approval process, at a much earlier stage in Plan development, the Commission would vote on the general concept for each Innovation Plan ("Innovation Plan Concept")—in particular, whether it meets the threshold for "innovativeness," whether it has been developed following a sufficient community engagement process, and whether it will enable the County to develop strong evaluation and learning goals. Counties would submit an Innovation Plan Concept to the MHSOAC and it would be added to the calendar for "concept approval." Commissioners would discuss the Plan Concept (using the discussion guide described in Recommendation 3d), provide feedback, and vote on whether the Concept should be approved, rejected, or modified. (This concept approval would be similar to the initial approval Counties have if they sign on to a Multi-County Collaborative.)

If the Concept *does not* receive approval, Counties would have the option to revise the Plan Concept or deprioritize it in favor of a different plan. If the Plan *does* receive concept approval, Counties would continue to develop the details of the Innovation Plan. Upon completion, the County would submit the full Plan to MHSOAC staff, who would review if it meets regulatory requirements (e.g., budget, CPP, evaluation) and has stayed true to the Plan Concept, and if so, add it to the consent agenda for the next Commission meeting.

(The MHSOAC may want to consider exceptions to a Plan being added to the consent agenda after receiving concept approval, such as if a Plan is above a certain dollar amount (e.g., in the top ten percent of size for Innovation Plans), then it automatically must go up for a full vote, or if a Commissioner specifically asks during concept approval for a Plan not to be placed on the consent agenda.

The MHSOAC could also consider automatically providing a planning grant to all Counties who receive concept approval that could be used to fund activities related to developing the concept into a full Plan.

NEXT STEPS

If the MHSOAC decides to adopt a multi-stage approval process, the next step would be to work with Counties and Commissioners to understand the expectations for what should be included in an Innovation Plan Concept in order for Commissioners to be comfortable with voting on it. As a starting point, we would recommend a five-page maximum outline, with the following guidelines for structure:

- One page on the challenge they are trying to solve
- One page on the CPP process
- One page on the proposed approach
- One page on how why the approach is innovative
- One page on evaluation design and what the County hopes to learn from the project

Recommendation 6. Develop a community engagement resource for Counties, identifying tactics for deeper community engagement and lessons learned

The Innovation community reflected varying experiences in how Counties engage their communities when developing Innovation Plans. Many Counties expressed that it is challenging to enable a level of community engagement through the planning process that is authentic and inclusive, while still being feasible within time, budget, regulatory constraints. Others told us that Counties can sometimes fall short of including unserved, underserved, and inappropriately served racial, ethnic, and cultural populations of various age groups adequately within the planning process, and that they don't always have a clear sense for what constitutes best practice and/or tactics that others have used successfully to build stronger engagement.

To address these challenges, we recommend that the MHSOAC work with Counties, Commissioners, consumers, family members, and stakeholder advocacy groups to develop a basic starter/refresher resource for Counties that outlines successful strategies for strengthening community engagement practices.

When possible, the community engagement resource should draw from learnings surfaced from CRDP Phase 1. For example, the CRDP Strategic Plan includes a recommendation for replicating models for community engagement based on the project's Strategic Planning Workgroups (SPWs). SPWs were successful in effectively engaging specific unserved, underserved, and inappropriately served populations in a meaningful way, soliciting their input and incorporating their feedback in the development of policy recommendations and the identification of community-based best practices.[11]

In partnership with CAMHPRO and NAMI, we have begun developing an outline for a community engagement reference resource. We hope that this outline can serve as a starting point. It includes:

- Tactics to facilitate deeper community engagement (including methods for identifying what communities have historically been left out of Innovation planning)
- Information about technical assistance and other resources to support the community engagement process, including resources that communicate the purpose and limitations of the Innovation Component
- Strategies for assessing and communicating community engagement when writing an Innovation Plan

NEXT STEPS

The resource library will include an outline for the community engagement resource, highlighting key content as well as next steps for further collaboration with the Innovation community (in particular, stakeholder advocacy contract holders) to refine and publicize the resource. This could include developing the resource into a set of "principles" for what a good CPP process looks like.

[11] https://cpehn.org/assets/uploads/archive/resource_files/crdp_strategic_plan.pdf. Strategy 23 pp.38

Recommendation 7. Further publicize and clarify existing flexibilities that strengthen County planning processes

The Innovation planning and approval process has many requirements (e.g., robust CPP process, local mental or behavioral health board or commission approval, County Board of Supervisors approval, Commission calendaring and approval). To aid Counties in their planning for these requirements, the MHSOAC has introduced flexibilities in the approval process designed to reduce unnecessary constraints to innovation while staying true to the requirements in the MHSA. However, in our interviews, we learned that many County leaders were unaware of these flexibilities and how to take advantage of them. Therefore, we recommend that the MHSOAC circulate a resource that consolidates, clarifies, and further publicizes these existing flexibilities.

The following flexibilities (as well as any other flexibilities identified by the MHSOAC team) should be included in the resource:

- **Planning Grants:** Counties can request (via a simple, low-burden approval process) to use up to $100,000 of their Innovation allocations for planning.
- **CPP Process Allocations:** Counties may allocate up to 5% of their MHSA allocations for the CPP process.
- **Local Board of Supervisors Approval:** A Plan can be submitted for MHSOAC approval *before* the County receives local Board of Supervisors approval, so long as there is a calendared date for the Plan to appear before the Board of Supervisors.
- **Delegated Authority and Consent Agenda**: Innovation Plans that make certain requirements (e.g., a County joining an existing Multi-County Collaborative) can be approved via the Executive Director or via Consent Agenda.

Information in the resource should include how each flexibility intends to remove barriers to Counties in creating strong Innovation Plans, when each flexibility was introduced, and how Counties can take advantage of them.

NEXT STEPS

As part of the resource library, we will develop an outline to describe process flexibilities and propose a process for further development of this resource, including how to incorporate it in the existing MHSOAC Innovation Review Process flowchart in the Innovation Toolkit.[12]

[12] Innovation Toolkit. https://mhsoac.ca.gov/sites/default/files/documents/2018-05/INN_Toolkit_Full.pdf

Recommendation 8. Develop additional orientation materials for new Commissioners

The Innovation Component of the MHSA is unique in both the particularities of its approval process and its ultimate goal of "develop[ing] new best practices in mental health services and supports."[13] This leads to a significant learning curve for anyone, including Commissioners, to understand Innovation's purpose and the intricacies of how it works. To accelerate this learning curve, we recommend that the MHSOAC build upon existing onboarding materials for Commissioners.

Currently, new Commissioners receive a binder with background materials detailing their duties and providing information on the Innovation Plan approval process. As part of its Racial Equity Action Plan, the Commission is examining how to improve the onboarding experience for new Commissioners. Building on that important work, we would also recommend adding the following elements, both in the binder and in a live orientation session:

- A description of the format and structure of Commission meetings, including Commissioners' typical roles
- A detailed background of MHSA Innovation, including key facets of Innovation Plans, any documents clarifying the definition of Innovation and/or a list of types of projects that would qualify as innovative (see Recommendation 1)
- Resources available to Commissioners in assessing Innovation Plans, including MHSOAC Staff Analysis and any discussion guide adopted by the Commission (See Recommendation 3c)
- Key learnings from recent Innovation Projects
- List of barriers to Innovation, identified in earlier parts of this systems analysis project

Additionally, the MHSOAC should consider encouraging Commissioners to hold ad hoc introductory conversations with members of the Innovation community, such as the CBHDA, organizations that hold a Stakeholder Advocacy Contract with the MHSOAC, MHSOAC Committees and Subcommittees, MHSOAC staff and managers (especially those managing Innovation and the Commission's grants), and others. This approach would equip Commissioners at the beginning of their tenure with information and relationships that would accelerate the learning curve to understanding how the Innovation Component works.

Finally, the MHSOAC should consider making an abbreviated version of this onboarding available to existing Commissioners as a "refresher training."

NEXT STEPS

If the MHSOAC decides to adopt this mechanism, we recommend that staff get input from current Commissioners (including newer and more tenured members) about which elements would be helpful to include in a more robust orientation in addition to or instead of those described above. Participating

[13] 9 CCR § 3200.184

in a more in-depth orientation and introductory meetings would add to Commissioner workload and may be difficult to schedule, so it is important that any additional onboarding be carefully curated.

Appendix I. Proposed Tools & Resources

The below table summarizes each of the tools (described in the Innovation Action Plan) that will be developed as part of this project's resource library. The proposed format and rationale to create each tool is detailed in the corresponding recommendation within this Innovation Action Plan. The deliverable indicates the proposed draft format/version for each tool to be developed by as part of the resource library. When developing these resources, we will also outline next steps and highlight areas for input from the Innovation community.

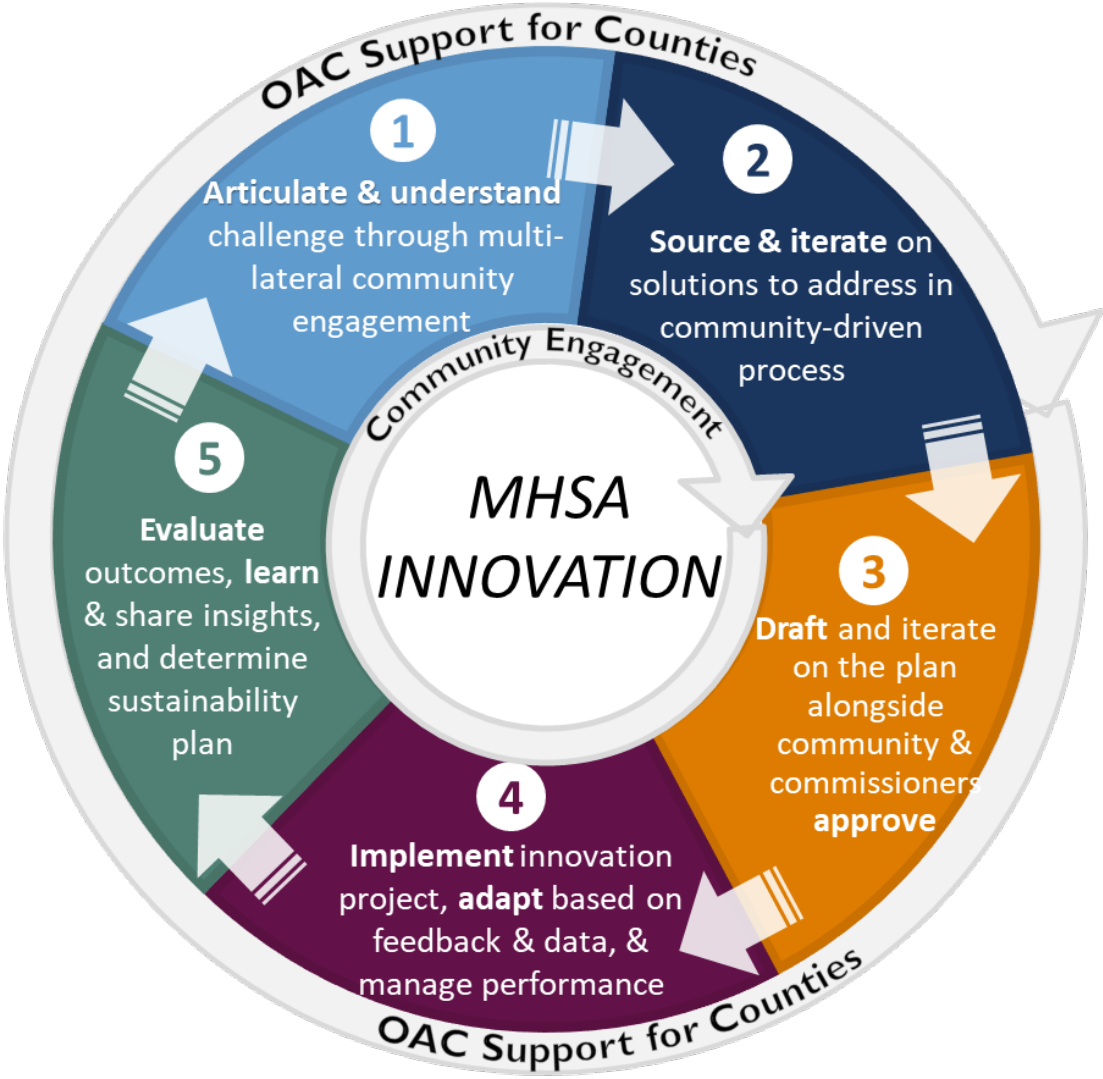
Tool Name	Description	Corresponding Recommendation in IAP
Innovation FAQ resource	Draft of resource	1a (Figure 1)
List of types of projects that would qualify as "innovative"	Draft of resource	1b (Figure 2)
Guide for working with evaluators	Draft of resource	2a
Overview of plan review tools (Recommended Template, Staff Summary, discussion guide)	Draft of resource	3 (Figure 3)
Simplified Recommended Innovation Project Plan Template	Recommended edits to template	3a
Discussion guide Commissioners and others can use to assess Plans	Outline and series of starter questions	3b (Figure 7)
Case studies of stand-out practices and processes	Five case studies	4a
List of ideas for annual convening	Draft agenda	4b
Template for database of Innovation Projects with qualitative and quantitative outcomes	Recommended updates to current dashboard and recommended metrics	4c
Community engagement resource for Counties	Outline for resource, with some content drafted	6
Overview of Innovation process flexibilities for Counties	Draft of resource	7
Orientation materials for new Commissioners	Draft structure for orientation	8
Roadmap for dissemination of resources	Proposed roadmap	N/A

Appendix 2. Systems Analysis Project Discussion Group Participants

Alfredo Aguirre	**Former Behavioral Health Director**, San Diego County
Andrea Wagner	**Program Manager,** Lived Experience, Advocacy, and Diversity Program, CAMHPRO
Brenda Grealish	**Executive Officer,** Council on Criminal Justice and Behavioral Health, CDCR
Elia Gallardo	**Director,** Government Affairs, CBHDA
Jim Gilmer	**Co-Coordinator,** African American/People of African Descent Strategic Planning Work Group (CRDP Phase 1)
Jim Mayer	**Former Chief of Innovation Incubator,** MHSOAC
John Aguirre	**ACCESS Ambassador,** Stanislaus County
Karen Larsen	**HHSA Director, Mental Health Director, and Alcohol and Drug Administrator,** Yolo County
Kylene Hashimoto	**Youth Innovation Committee Member; Founder,** The Wildfire Effect
Matthew Diep	**Youth Innovation Committee Member; Founder,** Psypher LA
Norma Pate	**Deputy Director of Administrative and Legislative Services,** MHSOAC
Phebe Bell	**Behavioral Health Director,** Nevada County
Sarah Eberhardt-Rios	**Health and Human Services Branch Director,** Sutter-Yuba County
Sharmil Shah	**Chief of Program Operations,** MHSOAC
Sharon Ishikawa	**MHSA Coordinator,** Orange County
Tanya McCullom	**Program Specialist,** Office of Family Empowerment, Alameda County
Travis Lyon	**MHSA Coordinator**, Tehama County

Appendix 3. Continuous Improvement Framework

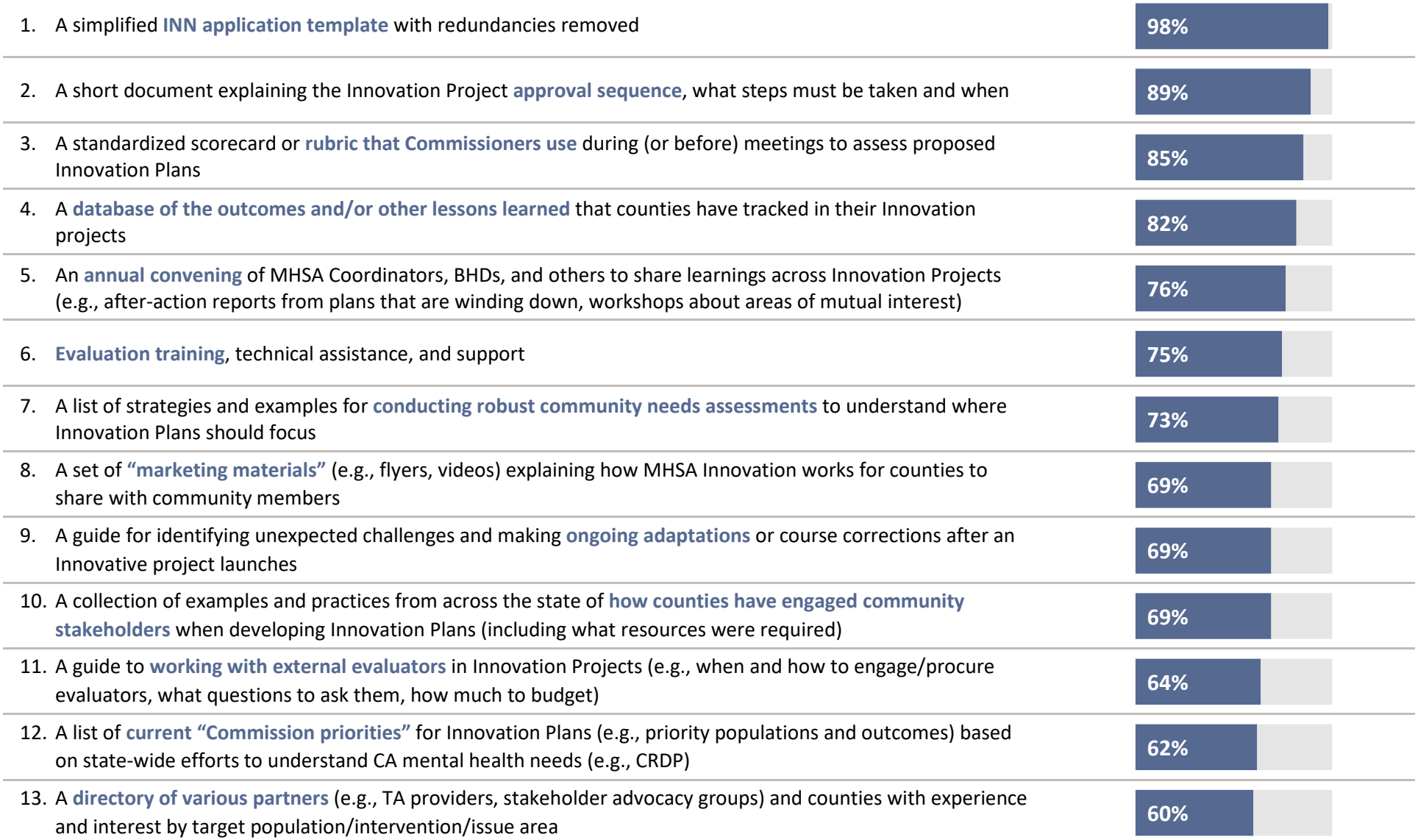
We developed this continuous improvement framework as part of this project's resource library. It is based on our review of past Innovation Plans and on our research on innovation in the public sector (see Methodology Section).



Appendix 4. MHSA Coordinator Survey Results

We asked MHSA Coordinators to rate potential resources on how useful they would be for developing Innovation Plans and implementing projects. We distributed the survey with help from the CBHDA.

Percent of respondents who rated the potential resource "extremely" or "very useful" (n=55)



Appendix 5. More Suggestions from the Innovation Community

Below, we have included suggestions offered to us by the Innovation community that did not ultimately make their way into the Innovation Action Plan, but that we wanted to catalogue and highlight as ideas for future work.

Suggestion
Is there an opportunity to suggest working with the Governor and/or legislature on the reversion timeline or process? That has proved to be a real challenge for counties
Shift Recommendation 2b from an "Innovation Support Group" to an "Innovation Review Board," which should include Commissioners and have the authority to make "Innovation" determinations. At an early stage, the project should be presented to the Review Board for discussion and feedback and this group should determine whether a county should develop a full Innovation plan. If this group determines a proposal is Innovative learning early on, this requirement should be considered met. When completed, so long as the final Innovation Plan does not deviate from the concept brought forward to the group, this requirement should not be redebated.
It would be great if the OAC could create standards for counties in how to manage stakeholder engagement while clarifying what each plan should include so counties don't have their plans declined.

Appendix 6. Feedback from MHSOAC Committee Members

This Innovation Action Plan was shared via email with the Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee members along with an electronic survey for them to submit feedback on the document. We received three total responses that are included verbatim in the table below; each bullet represents the response of one committee member. To preserve anonymity, we have removed some personally identifiable information from the responses (denoted with brackets).

Recommendation 1. Supplement the definition of innovation with further guidelines	• *The most important in my opinion is adapting a project that meets specific general goals that shows frequent successes and unsuccessful data or outcomes. In order to have a solid result that can be adapted and have a positive response.* • *1c. County government employees will look for and require a roadmap to navigate the Innovation Process* *1d. County Staffers must have clear definitions for everything they do. This is based on HR and the "meeting expectations" category pertaining to the duties of their job in connection with their annual raise.* *1e. Yes to a 2-5 sentences paragraph that supplement the definition of Innovation by keep the focus narrow.* *1f. First sentence is "mission statement".* *1g. Second sentence is "giver/receiver" (county/partners/what kind of clients).* *1h. Third sentence is Project Goals (no more than 4).* *1i. Fourth Sentence is Steps to Project Goals (no more than 3).* *1j. Innovation Projects should be set up in a scheduling tool.* *1k. Microsoft Project as a scheduling tool that can handle projects with Phases using a simple waterfall process. They can be connected with their own start and end dates. This is where counties will report-out to the MHSOAC and its Commissioners.* *1l. Innovation Planning should be a "gated process" with the counties being required to complete each Project Goal and its related Project Phase before going forward to the next.* *1m. This will facilitate "Lessons Learned" as reports are shared among all within the counties' statewide grouping of small-medium-large county budgets.* *1n. This process will also guarantee that the counties are assessing their populations accurately and regularly and re-districting where needed, thereby understanding and serving those communities in greatest need while we (at the MHSOAC) learn, document and share from these new approaches that are being vetted.*
Recommendation 2. Expand and deepen technical assistance to Counties	• *Innovative Working Group is a great idea, having more assistance from Counties regarding any resources they can provide to their communities would be great.* • *I recently made a comment and recommendation on the importance of having a more specific checklist for counties when it comes to the data collection. And an equal amount of assistance required.* • *I think this is an excellent idea as I see my name representing my Committee as I have experience as [personally identifiable information removed]. Compensation could come in a variety of ways, with the most important thing being that the Innovation WORKING GROUP is working. The Work will need structure and they (IWG) will need discipline with meeting program deliverables and IWG will need a direct reporting relationship to Toby, Norma, Brian, Dawnte, and Sharmil. I also think that 4-hour sessions would allow the IWG time to interact with the counties (2-hours) and then*

	spend 2-hours with MHSOAC ensuring that legal requirements for Innovation Projects are being met. Also this can burn through the backlog and then be adjusted when things are caught up.
Recommendation 3. Further clarify expectations for Plan development	• *Maybe more meetings to go over Plan Developments.* • *If there has to be an adjustment made in the plan, have a more specific timeline to recognize that. That will help to know what seems not to work much faster and come up with other solutions timely.* • *3d.The IWG can be the bridge between the counties and the MHSOAC by managing target dates.* *3e. Project dollars should be managed by MHSOAC staff as they could be considered confidential.* *3f. To mitigate county staff confusion and manage "The Process" better we could tie Innovation Project Plans to relevant state regulation.* *3g. This will give a "gated process" whereby Project Phase must be completed and approved before releasing funds to move on to the next phase.*
Recommendation 4. Develop mechanisms to accelerate the diffusion of learnings from Innovation Projects	• *This is fine.* • *Allow there to be separate additional funds available to the project, if needed, for additional hires. If they are not used or there is left it can only be used for that and can be used at different times. The amount could be a fixed or based on a certain percentage?* • *4e. Create a series of on-line lectures instructing the counties on what we want.* *4f. This way the counties can watch the "on demand" lectures and step through the process on their own before they come to the annual Innovation convening.* *4g. At the annual convening the counties would be grouped with others as either small, medium, or large and shall attend lectures and seminars based on their county MHSA budget.* *4h. Case studies will be focused on success stories related to differing culture and language* *4i. Homelessness, adult mental health, substance abuse and school related mental health issues are common threads and best practices and solutions shall be discussed.* *4j. Perhaps the RAND Corporation can attend our symposium and give a lecture on how to create our own think tank including methodologies on solutions management.*
Recommendation 5. Test a multi-stage approval process that provides concept approval earlier in the Plan development cycle	• *This is good.* • *This was where my ideas have been really focused on. in the initial phase of collecting the shortcomings at a faster rate, is the only way the whole Innovation plan can be successful. And the guidelines must be followed up according to an interactive outline checklist submitted to the MHSOAC.* • *5a. In my experience with master program scheduling all programs have a multi-stage approval process as I stated earlier with the use of a "gate".* *5b. A gate is an approval process that engineers use to certify that a piece of equipment will work as planned or a mathematical equation will function as stated.* *5c. A Meeting takes place and the object undergoes Testing and signatures are required to "sign-off" on the particular process, procedure, equipment or equation to ensure its reliability when it is doing its function.* *5d. The Program Concept (The Idea) is approved at the very beginning along with the Giver/Receiver (Seller/Buyer), then comes Authorization (Budget) and then comes the Mission Statement (The Work).*

	5e. Creating a Program with a phased approach gives us (MHSOAC) greater control over assets and resources thereby reducing liabilities and mitigating loss while giving the general public knowledge about their own wellbeing so that they can live better lives.
Recommendation 6. Develop a community engagement resource for Counties, identifying tactics for deeper community engagement and lessons learned	• *How about the hard to reach population?* • *Something that shows equal amount of engagement participation of community members throughout the process consistently. Creating a wider range of spaces for community engagement can take place.* • *6a.The MHSOAC could possibly allow through "certified" channels the opportunity for SMIs that have completed a county sponsored Innovation program the opportunity to say a few words and let us know how these programs affected them directly via a short video clip that can be sent to the MHSOAC, then cleansed and posted by staff to the MHSOAC website.* *6b. I was a part of the Phase I of CRDP and this was very effective with SMIs.* *6c. "Deeper Engagement" to me means programs that serve more clients successfully.* *6d. How do we measure success?* *6e. We have to find the success stories and then echo the individual achievement.* *6f. Right now in 2021, that means "permanent supportive housing" or "PSH" as well as "substance abuse treatment"* *6g. These two initiatives will lead to other mental health success stories including school-based mental health programs that address teen suicide.*
Recommendation 7. Further publicize and clarify existing flexibilities that strengthen County planning processes	• *7a. The LA County Planning Process is not accessible to everyone for a variety of reasons.* *7b. Perhaps Counties can begin to encourage citizens and promote a Community Planning Process by becoming advocates themselves through local neighborhood watch programs.* *7c. Counties could advertise the community planning process through the various doorbell monitoring systems that are on the market today. This could dissuade the concept of NIMBY.*
Recommendation 8. Develop additional orientation materials for new Commissioners	• *Weekly check list with a short written summary and data of current progress. During initial phase. That will also contribute to earlier phasing out and would be beneficial for the Project and the MHSOAC.* • *8a. Yes an Orientation Package should be provided to the MHSOAC Commissioner's when they on-board.* *8b. I am not familiar with the current binder; however, it appears that more information should be given to Commissioner's so that they can make more informed decisions.* *8c. May I suggest using a project management methodology called the "phase-gate process" mentioned by me in this exercise to provide an easy, complete, structured and transparent process that is visible to everyone.* *8d.The project (or Plan) is broken down into smaller stages or phase, each delimited by a "gate" whereby decision-makes meet to review the project.* *8e. This allows management to build a clearly understandable roadmap for management, stakeholders and consumers alike.*
Please use this space to share any other feedback you have about the Innovation Action	• *No feedback currently.* • *Tackling challenges in any aspect is the beginning process of opening the window of success wider. I feel strongly on how much opportunity for growth is needed and its with innovation project plans that pave a way for change. So much*

Plan that is not connected to a specific recommendation.	*dedication is taken tom come up with it but it comes difficult with not enough resources or initial allocation of trial and error at a much faster rate.* • *I think this is a wonderful idea, one that will improve individual productivity as well as overall Agency credibility. Thank you for allowing me to be a part of the organization.*

APPENDIX B: IAP RECOMMENDATION PRIORITIZATION MATRIX (1/2)

Recommendation	Impact	Ease of Implementation	Resources	Related recommendations
1. Supplement the definition of innovation with further guidelines				
Create an Innovation FAQ resource to clarify areas of ongoing uncertainty	●●●	●	$	All
Develop a publicly available (non-exhaustive) list of types of projects that would qualify as "innovative."	●●○	●	$	1A, 2A, 2B, 3B, 4A, 4C, 4D, 6, 8
2. Expand and deepen technical assistance to Counties				
Strengthen support functions to meet County needs	●●●	●	$ $ $	1A, 1B, 2B, 3A, 3C, 4A, 4B, 4C, 5, 6, 7
Consider forming an "Innovation Working Group"	●●○	●	$ $ $	1A, 1B, 2A, 3A, 3C, 4A, 4B, 4C, 5, 6, 7
3. Further clarify expectations for Plan development				
Simplify the Innovative Project Plan Recommended Template	●●○	●	$	1A, 2A, 2B, 3B, 3C, 4A, 4C, 4D, 5, 6, 7
Create a discussion guide for the Commission and others to use when assessing Plans	●●○	●	$	1A, 3A, 3C, 4A, 4C, 4D, 5, 6, 7, 8
Develop target dates for submitting Plan concepts and drafts to MHSOAC staff	●○○	●	$	1A, 2A, 2B, 3A, 3B, 4B, 5, 6, 7

Impact *(How much will this improve MHSA Innovation?)*

Less impact → *More impact*

○○○ → ●●●

Ease of Implementation *(How difficult will it be to make this change?)*

Difficult to implement → *Easier to implement*

● ● ●

Resources *(What financial / staff resources are required to implement?)*

Less resources → *More resources*

$ → $ $ $

SOCIAL FINANCE

APPENDIX B: IAP RECOMMENDATION PRIORITIZATION MATRIX (2/2)

Recommendation	Impact	Ease of Implementation	Resources	Related Recommendations
4. Develop mechanisms to accelerate the diffusion of learnings from Innovation Projects				
Publish case studies of stand-out practices and processes	●●●	●	$ $ $	1A, 1B, 2A, 2B, 3A, 3B, 4B, 4C, 4D, 6, 8
Host an annual Innovation convening	●●○	●	$ $ $	1A, 2A, 2B, 3C, 4A, 4C, 4D, 6, 8
Create a database of Innovation Projects	●●●	●	$ $ $	1A, 1B, 2A, 2B, 3A, 3B, 4A, 4B, 4D, 6
Require Counties to present concise outcomes and findings summaries at Commission meetings	●●○	●	$ $ $	1A, 1B, 3A, 3B, 4A, 4B, 4C, 6, 8
5. Test a multi-stage approval process that provides concept approval earlier in the Plan development cycle	●●●	●	$ $ $	1A, 2A, 2B, 3A, 3B, 3C, 7, 8
6. Develop a community engagement resource for Counties, identifying tactics for deeper community engagement and lessons learned	●●●	●	$ $ $	1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A, 4B, 4C, 4D, 7, 8
7. Further publicize and clarify existing flexibilities that strengthen County planning processes	●●●	●	$ $ $	1A, 2A, 2B, 3A, 3B, 3C, 5, 6, 8
8. Develop additional orientation materials for new Commissioners	●●○	●	$ $ $	1A, 1B, 3B, 4A, 4B, 4D, 5, 6, 7

Impact *(How much will this improve MHSA Innovation?)*

Less impact → *More impact*

○○○ → ●●●

Ease of Implementation *(How difficult will it be to make this change?)*

Difficult to implement → *Easier to implement*

● ● ●

Resources *(What financial / staff resources are required to implement?)*

Less resources → *More resources*

$ $ $ → $ $ $

SOCIAL FINANCE

MISCELLANEOUS ENCLOSURES

October 27, 2022 Commission Meeting

Enclosures (5):

(1) Napa County Innovation Project - Multi-County Full Service Partnership (FSP) Innovation Project Plan and Staff Analysis
(2) Evaluation Dashboard
(3) Innovation Dashboard
(4) Department of Health Care Services Revenue and Expenditure Reports Status Update
(5) Tentative Upcoming MHSOAC Meetings and Events

INNOVATION PROJECT PLAN

Participating Counties:

- Cohort 1: Fresno[1]; Sacramento; San Mateo[2]; San Bernardino; Siskiyou; Ventura
- Cohort 2: Stanislaus, Lake
- Cohort 2 Expansion: Napa

Project Title: Multi-County Full Service Partnership (FSP) Innovation Project

Duration of Project:

- Cohort 1: January 1, 2020 through June 30, 2024 (4.5 years)
- Cohort 2: August 1, 2021 through January 30, 2026 (4.5 years)
- Cohort 2 Expansion: Oct 1, 2022 through March 31, 2027 (4.5 years)

Section 1: Innovation Regulations Requirements Categories

General Requirement: An Innovative Project must be defined by one of the following general criteria. The proposed project:

X Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system

☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose: An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

☐ Increases access to mental health services to underserved groups

X Increases the quality of mental health services, including measured outcomes

X Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

[1] Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project; this plan was approved by the MHSOAC in June 2019.

[2] San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but intends to participate in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Section 2: Project Overview

Primary Challenge

Since the creation of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those most in need across the state. In particular, Full Service Partnerships (FSP) support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to serving and partnering with individuals living with severe mental illness. In many counties, FSP programs are effectively improving life outcomes and staff can point to success stories, highlighting dedicated staff and programs tailored to specific cultural groups and ages.

Despite the positive impact of FSP, the program has yet to reach its full potential. Many Californians with serious mental illness still struggle to achieve fuller, more independent lives and achieve the outcomes that MHSA prioritizes (i.e., reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness).

Counties and FSP providers have identified two barriers to improving and delivering on the "whatever it takes" promise of FSP:

The first is a *lack of information* about which components of FSP programs deliver the greatest impact. To date, several counties have strived to establish FSP programs to address specific populations and specific underserved regions, but data collection has been limited or inconsistently implemented. Additionally, there have been few coordinated efforts or comprehensive analyses of this data. This has resulted in an approach to program development that is, in its most noble of intent, driven by a desire to serve the community, but based often only on a best guess as to what will be effective. Counties desire a more data-driven approach to program development and continuous improvement, one rooted in shared metrics that paints a more complete picture of how FSP clients are faring on an ongoing basis, is closely aligned with clients' needs and goals, and allows comparison across programs, providers, and geographies. As one participating county (San Bernardino) described during an early planning meeting for this project, "Community members, FSP staff, and clinicians have identified an opportunity for data collection [and metrics] to be better integrated with assessment and therapeutic activities." These metrics might move beyond the current state-required elements and allow the actionable use of data for more effective learning and ongoing program refinement. Several counties and their provider staff, for example, indicate that FSP data is collected for state-mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, typically by FSP providers; however, meaningful FSP outcomes are designed to be measured with cross-agency data (such as health care, criminal justice, etc.), meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources.

The second barrier is *inconsistent FSP implementation*. FSP's "whatever it takes" spirit has allowed necessary flexibility to adapt the FSP model for a wide variety of populations and unique local contexts. At the same time, this flexibility inhibits meaningful comparison and a unified standard of care across the state. During early planning conversations for this project, several counties indicated the need to improve how their county collects and uses FSP program data, particularly as it relates to creating

consistent and meaningful criteria for eligibility, referral, and graduation. As one participating county (San Bernardino) described, "consumers have expressed interest in a standardized format for eligibility criteria and [seek] consistency in services that are offered and/or provided." While some variation to account for local context is to be expected, standardizing these processes using data, evidence, and best practices from across California offers the promise of significant performance improvements and better client outcomes.

To-date, several initiatives have worked on related challenges but have not identified solutions that are directly applicable to this dual-natured problem, or they have not attempted to apply solutions in a statewide context. Specifically:

- While Los Angeles (LA) County's Department of Mental Health has attempted to address these two primary challenges via their FSP transformation pilot, it remains to be seen whether the metrics, strategies, and data-driven continuous improvement approach is directly applicable to other California counties, or whether their solutions need further customization and refinement in order to be used as a statewide model. Through this Multi-County FSP Innovation Project, counties will also seek to compare and leverage needs and solutions from Los Angeles County, determining how their metrics and processes can be adapted to be relevant to California counties of all geographies and sizes.

- In 2011 and 2014, the Mental Health Services Oversight and Accountability Commission (MHSOAC) supported two efforts[3] that, at a high level, worked to develop priority indicators of both consumer- and system-level mental health outcomes through leveraging existing data, develop templates and reports that would improve understanding of FSP impact on these outcomes, and identify gaps and redundancies in existing county data collection and system indicators. However, these efforts did not work to implement these changes in a collective, consistent multi-county manner, nor did they focus on additional FSP elements such as eligibility and graduation criteria. This effort also did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs.

Proposed Project

This project responds to the aforementioned challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This Multi-County FSP Innovation Project represents an innovative opportunity for a diverse group of participating counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) to develop and implement new data-driven strategies to better coordinate FSP service delivery, operations, data collection, and evaluation.

The MHSOAC has supported Third Sector in leading counties through the process of developing and implementing this Multi-County FSP Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. A San Francisco-based nonprofit, Third Sector has helped behavioral and mental health programs nationwide create an

[3] The 2011 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and EMT Associates. The 2014 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and Trylon.

improved focus on outcomes, guiding government agencies through the process of implementing and sustaining outcomes-oriented, data-driven services focused on improved meaningful life outcomes. *Section 4: INN Project Budget and Source of Expenditures* below further describes Third Sector's experience and approach to transitioning social services programs to an outcomes orientation. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each participating county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Through participation in this Multi-County FSP Innovation Project, participating counties will implement new data-informed strategies to program design and continuous improvement for their FSP programs, supported by county-specific implementation and evaluation technical assistance. Staff will examine what matters in improving individual wellness and recovery and take a data-informed approach to program design, evaluation, and continuous improvement, leading to more effective and responsive FSP programs. The overall purpose and goals of the Multi-County FSP Innovation Project are to:

1. **Improve how counties define and track priority outcomes** and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
2. **Develop new and/or strengthen existing processes for continuous improvement** with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and effectively using qualitative and quantitative data to inform potential FSP program modifications
3. **Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined** through various state-level and county-specific reporting tools
4. **Develop a shared understanding and more consistent interpretation of the core FSP components** across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
5. **Increase the clarity and consistency of enrollment criteria, referral, and graduation processes** through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

Collaboration with a Statewide FSP Outcomes-Driven FSP Learning Community: In addition to the county-specific implementation technical assistance (TA) proposed in this Innovation Project, counties participating in this Innovation Project have co-developed and will participate in a concurrent, statewide Outcomes-Driven FSP Learning Community that Third Sector is leading with funding from the MHSOAC. County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders will engage in an interactive learning process that includes hearing and sharing lived experiences and developing tools to elevate FSP participant voice. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan and the Outcomes-Driven FSP Learning Community, helping each group build upon the work of the other, and develop a set of recommendations for any state-level changes to FSP requirements and/or data collection practices that are supported by a broad coalition of participating California counties.

Rationale for Using the Proposed Approach

Over the past several months, a broad group of counties (beyond the six counties participating in this Innovation Project) and Third Sector have convened to further unpack these challenges in a collective setting. Specifically, counties and Third Sector have collaborated in several virtual and in-person convenings to develop (i) an initial baseline understanding of counties' current FSP programs, including unique assets and challenges as it relates to defining and measuring important FSP client outcomes; data collection, data sharing, and data use; FSP services and population guidelines; and ongoing FSP performance management and continuous improvement processes, and (ii) an initial, shared plan for implementing outcomes-focused FSP improvements. Counties have expressed interest in developing a consistent and understandable framework for data collection and reporting across counties that better encourages actionable analysis of outcomes data and helps counties track the adoption of evidence-based practices.

The activities and goals proposed by this project are directly informed by these efforts and designed to respond to common challenges, capacity needs, and shared opportunities for FSP program improvements cited by counties.

This approach is also inspired by Los Angeles County Department of Mental Health's (LACDMH) journey to similarly focus their FSP programs on meaningful outcomes. This Innovation Project will build off LACDMH's early successes, implement adjusted strategies and approaches that are appropriate for a statewide context, and facilitate broader statewide exchange of collective learning and shared opportunities for improving FSP programs.

Number and Description of Population(s) Served

This project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide.

Research on the Innovative Component

This Innovation Project presents a new opportunity and innovative practice for participating counties in several ways:

1. Systems-Level Changes to Accelerate Performance

Instead of piloting a new FSP service or intervention, this project will reduce barriers that prevent counties from leveraging data and evidence to deliver better outcomes in FSP programs. While piloting and testing new service interventions remains a key tool for driving mental health services innovation, far too often promising innovations are expected to take root in systems that lack the infrastructure or capacity to support them—leading to suboptimal replication, challenges disseminating learnings, or failure to scale. This Innovation Project seeks to address those structural barriers by accelerating counties' ongoing efforts to use data and shared outcome goals to continuously improve their FSP programs, and do so in a manner that centers on increasing statewide learning.

2. County-Driven Origins with Statewide Impacts

This project also represents an opportunity for counties to drive state progress on reporting requirements, data collection, and data use. Many counties have individually struggled to track FSP client outcomes and make meaningful use of the existing data, but have to-date approached this problem alone. Recognizing these gaps and the power of a collective effort, counties themselves took the initiative to form this project as a response to their individual FSP program challenges and after hearing reflections on Los Angeles County Department of Mental Health's FSP transformation.

The county-driven origins of this project, paired with support from the MHSOAC, present a unique opportunity for participating counties to both (i) pursue county-specific implementation efforts that will drive lasting improvements within their *individual* FSP programs, and (ii) exchange learnings from these implementation efforts with other counties via a structured Outcomes-Driven FSP Learning Community designed to help increase *statewide* consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines.

3. Introducing New Practices for Encouraging Continuous Improvement and Learning

This project proposes to introduce new data-driven practices for managing FSP programs that center on improving clients' experiences and life outcomes and aim to increase consistency in how FSP programs are administered within and *across* different counties. It aims to develop and pilot continuous improvement processes and actionable data use strategies that are tailored to each participating county's specific context, and to generate new learning and shared consensus around FSP program and performance management best practices, alongside other participating counties. For example, a county may implement a new data dashboard that helps better illustrate client utilization of emergency services over time. This dashboard could be used to understand the relationship between an incoming client's needs, FSP services delivered, and changes in emergency services utilization over time. With this newly clarified data, county staff and/or providers would be able to understand and collaboratively discuss how different clients' needs should determine the services they receive, based on the historical success of other, similar clients.

4. Building on Individual County Progress to Create a Statewide Innovative Vision

This project will build on the continuous improvement tools and learnings emerging from Third Sector's existing work with the Los Angeles County Department of Mental Health's (LACDMH) FSP transformation, which centered on understanding and improving core FSP outcomes across all age groups, inclusive of improving stable housing, reducing emergency services utilization, and reducing criminal justice involvement. LACDMH's FSP transformation efforts have led to the development of new continuous improvement-focused "Learning Collaboratives" (regular meetings for providers and LACDMH to review outcomes data and discuss new service approaches), have surfaced new learnings and questions (e.g., how to define and measure positive FSP life outcomes like "meaningful use of time"), and have better standardized FSP programs via clarified enrollment and graduation criteria. This project presents an opportunity to deeply explore these learnings and tools at a statewide level in a collaborative manner, bringing counties together to explore and identify which FSP changes and innovations that LACDMH pursued (or purposefully did not pursue) might be most relevant and applicable across counties and, importantly, what modifications are necessary to implement these learnings at a state-level. More specifically, counties will explore how these changes may need to be adopted to meet the needs of counties with a variety of different attributes (e.g., smaller counties, more rural counties, counties with fewer program staff, counties with fewer contracted FSP programs, counties with different ethnic and racial makeups), balancing the desire for increased consistency with the spirit of meeting local context and needs.

5. Building Upon Existing Data-Focused Multi-County Collaborations

In addition, this project differs from existing, data-focused multi-county Innovation Projects in its focus on *implementing and applying* data insights to refine current learning and continuous improvement practices within FSP programs.

Four California counties are currently participating in an FSP "classification" pilot study sponsored by the MHSOAC and in partnership with the Mental Health Data Alliance. Through surveys of specific programs, this "classification" pilot seeks to identify specific components of FSP programs that are associated with high-value outcomes, namely early exits. The "classification" study can create and already has produced valuable learning on how counties can define outcomes like early exit and what FSP program characteristics map to a specified outcome. Moreover, it is an important demonstration of the value of collecting, maintaining, and sharing descriptive information about FSP program profiles that counties can correlate to FSP client outcomes.

However, the "classification" pilot does not propose to support counties in *applying* such learnings to their FSP programs, or in creating sustainable data feedback loops that leverage existing data to drive more real-time, continuous program improvements. Additionally, as a pilot, it is limited to the four participating counties and to a select few FSP programs and types (TAY, Adult, and Older Adult). Counties participating in this Multi-County FSP Innovation Project may look at the entire range of FSP services (including Child). Finally, this project will regularly connect with a larger group of counties than the scope of the "classification" pilot allows, leveraging the statewide Outcomes-Driven FSP Learning Community that is open to all counties (beyond the six counties contributing funds in this Innovation Project proposal) and that will encourage broader statewide input and collaboration.

In 2011, the UCLA Center for Healthier Children, Families, and Communities and EMT Associates, with support from the MHSOAC, developed templates and reports on statewide and county-specific data that would improve understanding of MHSA's impact, as well as evaluated existing statewide data on FSP impact. While this effort worked to identify current data collection practices and develop data templates, it did not suggest new outcomes domains, data collection, or metrics. Moreover, this effort did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs and services.

Similarly, in 2014, the UCLA Center for Healthier Children, Families, and Communities and Trylon, with support from the MHSOAC, reviewed existing data to develop priority indicators of both consumer- and system-level mental health outcomes and understand trends and movement in these indicators over time. This effort also identified gaps and redundancies in existing county data collection and system indicators. However, it did not attempt to *implement* new and consistent outcomes and metrics across multiple counties, nor did it develop regular continuous improvement processes that would leverage these specific measures in an action-oriented, data-informed manner.

This Innovation Project will go beyond both the 2011 and 2014 UCLA-led projects by focusing on both the implementation of new data collection and data use strategies, improving consistency and clarity of program guidelines (especially those around cultural or other specific types of services, eligibility, and graduation), and better understanding the connection between FSP services and outcomes. In this manner, this proposed Multi-County FSP Innovation Project proposes a new approach by expanding the extent to which counties attempt to align and create consistency.

5. *Proposing Changes to State-level FSP Data Requirements*

Building from the above, this project also intends to surface specific data collection and data use elements that counties can use to track their FSP outcome goals in a more streamlined, consistent fashion that can be feasibly applied across the state. Through this project, counties will develop a more cohesive vision around which data elements and metrics are most relevant and recommend changes to statewide FSP data requirements that better prioritize and streamline their use. Ultimately, these recommendations will aim to better support counties in understanding who FSP serves, what services it provides, and which outcomes clients ultimately achieve.

Stakeholder Input

Through individual discussions and group convenings, Third Sector and participating counties have discussed several strategies to ensure that the Multi-County FSP Innovation Project aligns with each county's goals, including priorities expressed in stakeholder forums. The Appendix includes more detail about each county's specific stakeholder needs, how this project addresses these needs, and how community planning processes in each county have impacted the overall project vision.

To date, Third Sector has supported counties in sharing the project with local stakeholders by providing summary materials (i.e. project descriptions and talking points) and answers to frequently asked questions. These materials were requested by counties and designed to be accessible to a broad audience. Counties such as Sacramento and San Bernardino have already used and adapted these for community planning meetings, soliciting feedback that has helped to inform this plan. Currently, all

participating counties have shared this project as a part of their three-year plan, annual update, or standalone proposal for public comment and county Board of Supervisors' review.

Furthermore, this project intends to engage county stakeholders—including program participants, frontline staff, and other key community partners—throughout its duration. In the implementation stage, engagement activities may include consulting and soliciting feedback from stakeholders when defining the outcome goals, metrics, service components, and referral and graduation criteria. Counties may choose to do this through focus groups, interviews, and working group discussions. Counties may also invite participants or community representatives to participate in statewide Outcomes-Driven FSP Learning Community events. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future county meetings that are open to the public. Additional description of these activities can be found in the *Work Plan and Timeline* section below.

Learning Goals and Project Aims

This project expects to contribute new learnings and capacities for participating counties throughout the county-specific TA and evaluation activities involved. Specifically, this project will seek to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to current FSP practices and program administration ("systems-level impacts"), and (B) the overall improvements for FSP client outcomes ("client-level impacts"). These two types of measures will help determine whether the practices developed by this project simplify and improve the usefulness of data collection and management and cross-county collaboration, and whether these practices support the project's ultimate goal of improving FSP client outcomes. Guiding evaluation questions that this project aims to explore include, but are not limited to, the following, as divided by each type of impact:

A) Systems-Level Impacts

Systems-level impacts will be assessed both within each county to understand local administration changes, as well as across counties to assess the impact of the multi-county, collaborative approach. Guiding evaluation questions to understand changes to individual county FSP administration are:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within each participating county?

Beyond the above county-level learning goals, the project also aims to understand the value of a collaborative, multi-county approach via understanding the level of county collaboration, the quality of it, and its ultimate impact. Guiding evaluation questions to assess the collaborative nature of this project include, but are not limited to:

6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the Outcomes-Driven FSP Learning Community and collective group of participating counties?
8. Which types of collaboration forums and topics have yielded the greatest value for county participants?

B) Client-Level Impacts

9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Evaluation and Learning Plan

This project will include two types of learning and evaluation.

First, Third Sector and the counties will pursue a number of evaluation and data analysis activities throughout the duration of the project (as described in the *Work Plan and Timeline* section below) to better understand and measure current FSP outcomes and identify appropriate strategies for improving these outcomes.

Second, Third Sector and the California Mental Health Services Authority ("CalMHSA") will support counties in identifying, procuring, and establishing an ongoing governance structure for partnering with a third-party evaluator. This third-party evaluator ("evaluator") will provide an independent assessment of the project's impacts and meaningfully assess the above learning goals via an evaluation. These efforts will support counties in articulating a meaningful, data-informed impact story to share across the state about the specific actions pursued through this project and the resulting learnings.

Counties have expressed a desire to prioritize onboarding this evaluator in the early stages of the project. The counties have emphasized the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as provide appropriate time to execute any data-sharing agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Currently, counties have identified RAND Corporation as a potential evaluation partner, given that RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in LA County. Participating counties, Third Sector,[4] and CalMHSA are currently taking steps to contract and onboard this evaluation partner.

A description and example measures for each of the nine evaluation questions follows below. Counties, with support from Third Sector and the evaluator, will develop and finalize these measures after contracting with the evaluator. The evaluation plan will include a timeline for defined deliverables and

[4] Third Sector will support counties in identifying and onboarding an evaluation partner, developing an ongoing governance structure for collaborating with the evaluator, and finalizing outcome measures and required data collection strategies through Third Sector's TA period (i.e., through November 2021). Third Sector does not plan to have an ongoing role in the Evaluation period (December 2021 through June 2024).

will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Evaluation planning activities will also include developing and confirming a strategy for each county to gather and collect data consistently, both for the purposes of creating a baseline understanding of current FSP program practices and performance, as well as for gathering data required for the evaluation.

The table below proposes potential qualitative and quantitative measures to assess both systems-level and client-level impacts. As described above, these system-level impacts will assess the positive value and changes experienced by participating counties and community stakeholders. These systems-level measures will be tracked during and following the initial 23-month implementation TA period, and directly answer guiding evaluation questions 1-8 above. Additionally, this project proposes to measure overall improvements in FSP client outcomes that may occur during the project timeframe (client-level impacts), to better understand evaluation question 9 above.

Example Measures	*Example Data Source*	*Relevant Evaluation Questions*
Systems-Level Impacts		
Policy changes that a county, the Department of Health Care Services (DHCS), or the MHSOAC implemented as a result of the project	Qualitative interviews of participating counties, state agencies	2, 5, 7
New FSP service approach as a result of the project	Qualitative interviews of participating counties, observational data from local FSP programs	2, 4, 5, 7
New data sharing mechanisms and/or agreements created to support ongoing evaluation, feedback, and analysis of disparities	Qualitative interviews of participating counties	3, 4, 7
Improvements or changes to FSP continuous improvement practices	Qualitative interviews of participating counties	2, 3, 4, 5, 7
New FSP metrics or data elements measured in each county	Qualitative interviews of participating counties	2, 3, 4, 5, 7
FSP metrics or data elements removed by each county due to lack of relevance or usefulness	Qualitative interviews of participating counties	2, 3, 4, 5, 7
Overall staff and clinician satisfaction with quality and impact of outcome measures selected, changes to data collection practices and service guidelines	Survey and/or qualitative interviews of participating counties	2, 3, 4, 8

	Increased confidence from staff and clinicians that measures tracked are meaningful for participants and/or are regularly reviewed and used to inform programs	Survey and/or qualitative interviews of participating counties	3, 4, 8
	Increased understanding across providers and/or county staff of how priority outcomes are defined and the corresponding data collection and reporting requirements	Survey and/or qualitative interviews of participating counties and local staff	3, 4, 8
Client- and Program Level Impacts			
	Changes in cross-system outcomes, such as:		
	Increased percentage of housing-insecure FSP clients connected with housing supports	Self-report via existing outcomes collections systems; data from local housing agencies	9
	Decreased recidivism for justice-involved FSP clients	Self-report via existing outcomes collections systems; data from local jails, and state prisons	9
	Decreased use of emergency psychiatric facilities	Self-report via existing outcomes collections systems; billing records from local hospitals via the county Mental Health Plan	9
	Increased percentage of clients engaging in recreational activities, employment, and/or other forms of meaningful use of time	Self-report via existing outcomes collections systems; additional new state and local data sharing agreements targeting tax and employment data	9
	Increased percentage of clients graduating FSP successfully	Enrollment and retention data from county FSP providers	9
	Increased program graduation rates for clients due to increased capacity (i.e., exits because clients are stable and re-integrated into the community)	Enrollment and retention data from county FSP providers	9
	Additional client-level outcomes, such as:		

	Reduced FSP outcome disparities (i.e. disparities by race, ethnicity, and language)	Comparison of pre- and post-outcomes on existing outcomes collections systems	9
	Timely access to programs and services aligned with individuals' long-term goals	FSP provider services and billing records	9
	Decreased utilization of crisis services in counties (e.g., emergency rooms, mental health, justice) due to increased emphasis on prevention and wellbeing	Data from county hospitals, jails, FSP providers	9

Note that the time period for observing and evaluating changes in outcomes and metrics may end sooner (e.g., end of 2023), so as to provide sufficient time for the evaluator to measure and synthesize evaluation findings and to share this information with counties. Third Sector, the evaluator, and participating counties will determine the exact measures and an appropriate evaluation methodology for assessing client-level impacts during the project.

Participating counties will identify and finalize these measures, data sources, and associated learning goals during the first year of the project, memorialized in a shared evaluation plan, with advisory support from Third Sector and the evaluator. As mentioned above, it will be beneficial to the overall project and the project's evaluation plan to identify and partner with an evaluator prior to finalizing the specific learning metrics, given the complex and systems-level nature of these changes. While the measures listed above are preliminary ideas and priorities identified by participating counties, Third Sector, the evaluator, and the counties will work to refine these measures in the first year of this project.

The evaluation plan will include a timeline for defined deliverables and will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Third Sector, participating counties, and the evaluator will also carefully consider and discuss strategies for mitigating possible unintended consequences when designing the evaluation and selecting measures to be tracked (e.g., any perverse incentives to graduate clients from FSP before they are ready). During the first year of the project, the evaluator and Third Sector will also support counties in identifying the appropriate method and steps to develop an accurate baseline of these measures. See the *Budget Narrative* section below for additional detail on the evaluation activities.

NOTE: Cohort 2 will adopt the same project aims, learning goals, and a similar structure for stakeholder input and evaluation.

Section 3: Additional Information for Regulatory Requirements

Contracting

Participating counties intend to contract with a technical assistance provider to support counties with project implementation activities. As described above in the *Proposed Project* section, the MHSOAC has

supported Third Sector (a San Francisco-based nonprofit) in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and responding to any challenges.

Participating counties will also identify and contract with an evaluation partner during the first year of the project. The evaluation partner will support counties in designing and implementing a shared strategy for assessing the project impact.

Counties plan to contract with Third Sector and the evaluation partner through the existing Joint Powers Agreement (JPA) viaCalMHSA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator and ensure appropriate regulatory compliance. CalMHSA will also develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties. As further detailed in Section 4, counties intend to use a portion of the Multi-County FSP Innovation Project budget to pay CalMHSA for this support.

Community Program Planning

The Appendix to the Innovation Plan includes more detail about each participating county's specific stakeholder needs, how this project addresses these needs, and what the overall community planning process has involved in each county. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input throughout the duration of this project, including participation via specific focus group and stakeholder interview activities outlined in the project work plan.

Alignment with Mental Health Services Act General Standards

This project meets MHSA General Standards in the following ways:

- It is a **multi-county collaboration** between Fresno, Ventura, Sacramento, Siskiyou, San Bernardino, and San Mateo to address FSP program challenges and opportunities
- It is **client-driven**, as it seeks to reframe FSP programs around meaningful outcomes for the individual, centering on holistic client **wellness and recovery**
- It seeks to create a coordinated approach to program design and service delivery, leading to an **integrated service experience for clients and family**
- It will establish a shared understanding of the core components of FSP programs and create a common framework that reflects best practices while adapting for local context and **cultural competency**
- **Diverse stakeholders** will be meaningfully engaged throughout the development and implementation of the project

Cultural Competence and Stakeholder Involvement in Evaluation

This project intends to engage each county's stakeholders (i.e., program participants, frontline staff, other key community partners) throughout its duration, including in evaluation activities. Example engagement activities may include, but are not limited to:

- Asking for input from FSP provider staff, clients or client representatives, partner agencies, and other stakeholders (via focus groups, interviews, surveys, and/or working group discussions) as counties identify and define outcome goals, develop meaningful metrics for tracking these goals over time, identify key FSP service components, and surface opportunities to clarify and streamline referral and graduation criteria
- Sharing and reviewing data gathered and analyzed throughout this project—including in the Evaluation period—with community members to gather additional input and insight in interpreting trends
- Inviting clients and/or client representatives to participate in statewide Outcomes-Driven FSP Learning Community events
- Soliciting qualitative feedback from stakeholders on how this project has helped (or hindered) FSP service delivery in each county and opportunities for further improvement
- Sharing learnings and regular updates from this project with stakeholders at MHSA community planning meetings and county-specific stakeholder committees

Innovation Project Sustainability and Continuity of Care

This Innovation Project does not propose to provide direct services to FSP clients. Each contractor (Third Sector; the third-party evaluator; CalMHSA) will operate in an advisory or administrative capacity and will not provide services to FSP clients. Throughout project implementation, participating counties will ensure continuity of FSP services, without disruption as result of this project.

Participating counties are strongly interested in sustaining any learnings, practices, and/or new statewide collaborative structures developed through this Innovation Project that demonstrate effectiveness in meeting the project goals. The Multi-County FSP Innovation Project work plan includes dedicated time and resources for sustainability planning among counties and Third Sector throughout each phase of the project. During the first two phases of the Implementation TA period (Landscape Assessment and Implementation), Third Sector will work closely with each participating county to ensure sustainability and transition considerations are identified and prioritized in developing new strategies for implementation, and that, by the conclusion of the project, county staff have the capacity to continue any such new strategies and practices piloted through this project.

In addition, the final two months of the Implementation TA period provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. These plans are further described below in the *Work Plan and Timeline* section). Counties will also use findings from the evaluation to

identify which specific practices or changes were most effective for achieving the different client- and systems-level impacts that the project will measure, prioritizing these for continuation in future years.

Similarly, while Third Sector will organize and facilitate the statewide Outcomes-Driven FSP Learning Community in 2020, the counties and Third Sector intend for the Learning Community to be largely county-driven and county-led. The counties and Third Sector will gather feedback on the efficacy of the Learning Community at various points throughout the first year of the project (2020) and will develop a plan for continuing prioritized activities in an ongoing fashion, whether through county-led facilitation, ongoing Third Sector support, and/or another strategy. The counties and Third Sector welcome and hope to solicit the MHSOAC's input in these conversations.

Data Use and Protection

Third Sector does not intend to request, collect, or hold client-level Personally Identifiable Information (PII) and/or Protected Health Information (PHI) during this Innovation Project. Participating counties may only provide Third Sector with de-identified and/or aggregate data related to their FSP programs. Any such de-identified and/or aggregate data provided will be stored electronically within secure file-sharing systems and made available only to employees with a valid need to access.

Should the third-party evaluator require access to individual level data and/or PII/PHI, CalMHSA, the evaluator and counties will take steps to ensure appropriate data protections are put in place and necessary data use agreements are established.

Communication and Dissemination Plan

Throughout the ideation and development of this Innovation Project, Third Sector has maintained ongoing conversation with the MHSOAC to share updates on county convenings, submit contract deliverables, solicit feedback about project decisions, discuss areas of further collaboration, and generally ensure alignment of interests, goals, and expectations. As the project progresses and moves into a phase of county-specific landscaping and implementation TA, Third Sector will continue to share regular updates, questions, and deliverables with Commission staff. These updates may include summaries of common challenges that participating counties experience on their FSP programs, from state-level data collection and reporting to performance management and continuous improvement practices. Based on these common challenges, participating counties intend to develop a set of shared recommendations for changes to state-level data requirements. Through the statewide Outcomes-Driven FSP Learning Community, these recommendations will be co-created and informed by counties across the state. Third Sector will share regular updates on Learning Community workshops and may invite Commission staff to attend select events. Additionally, Third Sector and the counties will collaborate with the MHSOAC to determine if and when presentations to the Commission may be valuable for further disseminating project learnings.

As the implementation phase of work comes to a close, Third Sector will work with participating counties to develop a plan for sustaining new outcomes-focused, data-driven strategies. This will include developing a communication plan for sharing project activities, accomplishments, and takeaways with the MHSOAC and DHCS. Third Sector will share counties' recommended revisions to state data

requirements, and it will initiate discussions about opportunities for the MHSOAC and DHCS to streamline and clarify guidelines and requirements, supporting more effective and responsive FSP programs. Third Sector will also share insights about the process itself, from Innovation Plan development to implementation TA, and reflect on the successes and challenges of these efforts, promoting a discussion about the sustainability and scalability of future Innovation Projects.

Work Plan and Timeline

Project Activities and Deliverables and Timeline

The Multi-County FSP Innovation Project will begin in January 2020 and end in June 2024 for a total project duration of 4.5 years. The project will be divided into two periods: an Implementation TA period and an Evaluation period. Throughout project implementation, counties will ensure continuity of FSP services.

In the first 23-month Implementation TA period, Third Sector will work directly with each participating county to understand each county's local FSP context and provide targeted, county-specific assistance in implementing outcomes-focused improvements. Third Sector will leverage a combination of regular (weekly to biweekly) virtual meetings or calls with counties' core project staff, regular site visits and in-person working groups, and in-person stakeholder meetings, in order to advance the project objectives. These efforts will build on learnings and tools developed in Third Sector's work with the Los Angeles County Department of Mental Health, as well as Third Sector's previous partnerships with other California and national behavioral health, human services, justice, and housing agencies. Each county will receive dedicated technical support with a combination of activities and deliverables tailored for their unique county context, while also having access to shared resources and tools applicable across all FSP programs and counties.

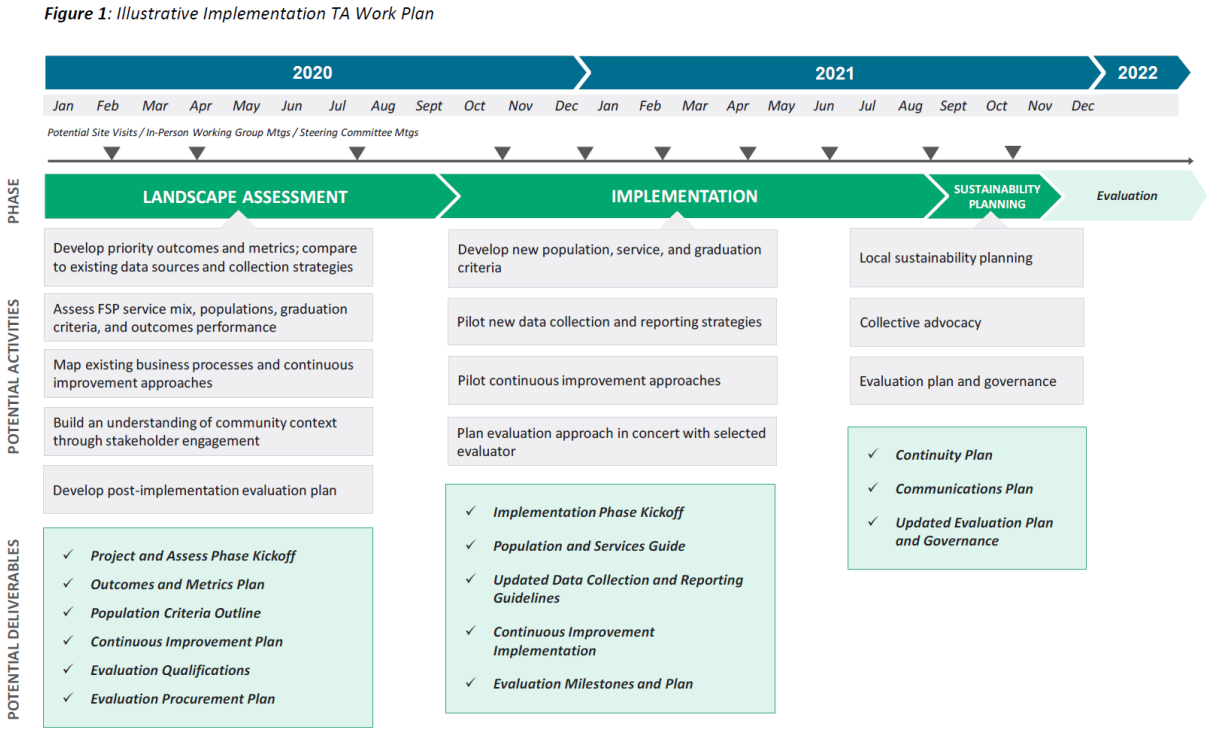
This Implementation TA period will be divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning). The activities and deliverables outlined below are illustrative, as exact phase dates, content, and sequencing of deliverables will depend on each county's needs and goals. County staff and Third Sector will collaborate over the next several months to identify each county's most priority activities and goals and to create a unique scope of work to meet these needs. See ***Figure 1*** below for an illustrative Implementation TA work plan and timeline by phase.

In the second period of the project, participating counties will pursue an evaluation, conducted by a third-party evaluator, with the goal of assessing the impacts and learning that this project produces.[5] This Evaluation Period and the overall Multi-County FSP Innovation Project will conclude at the end of June 2024.

NOTE: Cohort 2 and its expansion will follow a parallel workplan and timeline. See Appendix B and Appendix C for details.

[5] Note that this evaluator will also be a part of the Implementation TA period, given the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as to provide appropriate time to execute any data use agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Additional details on the timeline and plan for onboarding an evaluation partner follow in the sections below.

***Figure 1**: **Cohort 1** Illustrative Implementation TA Work Plan*



Phase 1: Landscape Assessment

The Landscape Assessment phase will act as a ramp-up period and an opportunity for Third Sector to learn about each county's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Building off of templates from national mental and behavioral health projects, Third Sector will customize deliverables and activities for each county's local FSP context. During this phase, Third Sector will work with county staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. County staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. Other example activities may include conducting logic models and root cause analyses to create consensus around desired FSP outcomes, reviewing current outcomes and performance data to understand trends, and gathering qualitative data about the client journey and staff challenges. By the end of this phase, each participating county will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.

Third Sector will produce a selection of the following illustrative deliverables, as appropriate for each county's unique context and needs:

- *Outcomes and Metrics Plan:* Recommended improved FSP outcomes and metrics to understand model fidelity and client success, including recommended areas of commonality, alignment, and consistency across counties
- *Population to Program Map:* A map of current FSP sub-populations, FSP programs, and community need, to illuminate any potential gaps or opportunities
- *Population Criteria Outline:* Recommended changes to population eligibility criteria, service requirements, and graduation criteria
- *Current State to Opportunity Map*: A map of metrics and existing data sources, including identification of any gaps and opportunities for improved linkages and continuity (e.g., auto-population of fields, removal of duplicate metrics, linking services or billing data to understand trends, opportunities to use additional administrative data sources to validate self-reported data)
- *Outcomes Performance Assessment*: An assessment of provider and clinic performance against preliminary performance targets, leveraging existing data and metrics
- *Process Map*: A process map identifying current continuous improvement and data-sharing processes and opportunities for improvement
- *Implementation Plan:* An implementation plan for new continuous improvement processes, both internal (i.e., creating improved feedback loops and coordination between county data, funding, and clinical or program teams) and external (i.e., creating improved feedback loops between county teams and contracted providers)

During this phase, Third Sector and the counties will develop a set of qualifications and work plan for procuring a third-party evaluator. Example evaluator-led activities and deliverables include:

- Recommended evaluation methodology (e.g., randomized control trial, quasi-experimental method, etc.)

- Work plan for executing any required data-use agreements and/or Institutional Review Board (IRB) approvals that may be necessary to implement the evaluation
- Evaluation plan that identifies specific outcomes, metrics, data sources and timeline for measuring client- and systems-level impacts
- Final impact report

Counties will select an evaluator based upon the qualifications and work plan described above. Following procurement and/or onboarding as appropriate, Third Sector, counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the evaluation, and any associated planning and preparing (e.g. validation of baseline FSP practices and performance) that should occur during the Implementation phase.

Phase 2: Implementation

Third Sector will provide individualized guidance and support to each county through the Phase 2 Implementation process, piloting new strategies that were developed during Phase 1. Understanding limitations on staff capacity, Third Sector will support county staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or project governance meetings. County staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP populations. As a result of this phase, county staff will have piloted and begun implementing new outcomes-oriented, data-driven strategies.

With Third Sector's implementation support, participating counties may achieve a selection of the following deliverables in Phase 2:

- *Referral Strategies*: Piloted strategies to improve coordination with referral partners and the flow of clients through the system
- *Population and Services Guide*: New and/or revised population guidelines, service requirements, and graduation criteria
- *Updated Data Collection and Reporting Guidelines*: Streamlined data reporting and submission requirements
- *Data Dashboards:* User-friendly data dashboards displaying performance against priority FSP metrics
- *Continuous Improvement Process Implementation:* Piloted continuous improvement and business processes to create clear data feedback loops to improve services and outcomes
- *Staff Training:* Staff trained on continuous improvement best practices
- *FSP Framework:* Synthesized learnings and recommendations for the FSP framework that counties and Third Sector can share with the broader statewide Outcomes-Driven FSP Learning Community for further refinement
- *FSP Outcomes and Metrics Advocacy Packet:* Recommendations on improved FSP outcomes, metrics, and data collection and sharing practices for use in conversations and advocacy in stakeholder forums and with policy makers.

Phase 3: Sustainability Planning

Throughout Phases 1 and 2, Third Sector will work closely with each participating to ensure sustainability and transition considerations are identified and prioritized during implementation, and that, by the conclusion of the project, county staff have the capacity to continue any new strategies and practices piloted through this project. Phase 3 will provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. Specific Phase 3 activities may include articulating lessons learned, applying lessons learned to other mental health and social service efforts, creating ongoing county work plans, and developing an FSP impact story. As a result of Phase 3, each participating county will have a clear path forward to continue building on the accomplishments of the project.

Third Sector will produce a selection of the following deliverables for each county:

- *Project Case Study:* A project case study highlighting the specific implementation approach, concrete changes, and lessons learned
- *Continuity Plan*: A continuity plan that identifies specific activities, timelines and resources required to continue to implement additional outcomes-oriented, data-driven approaches
- *Project Toolkit:* A project toolkit articulating the specific approaches and strategies that were successful in the local FSP transformation for use in similarly shifting other mental health and related services to an outcomes orientation
- *Communications Plan:* A communications strategy articulating communications activities, timelines, and messaging
- *Project Takeaways*: Summary documents articulating major takeaways for educating statewide stakeholders on the value of the new approach
- *Evaluation Work Plan and Governance:* An evaluation work plan to assist the counties and the evaluation partner in project managing the Evaluation period

Expected Outcomes

At the end of this project, each participating county will have clearly defined FSP outcome goals that relate to program and beneficiary priorities, well-defined performance measures to track progress towards these outcome goals, and a clarified strategy for tracking and sharing outcomes data to support meaningful comparison, learning, and evaluation. The specific implementation activities may vary based on the results of each county's landscape assessment, but may include the following: piloting new referral processes, updating service guidelines and graduation criteria, using qualitative and quantitative data to identify program gaps, sharing data across providers, agencies, and counties, streamlining data practices, improving data-reporting formats, implementing data-driven continuous improvement processes, and recommending changes to state-level data requirements.

Section 4: INN Project Budget and Source of Expenditures

Overview of Project Budget and Sources of Expenditures: All Counties

The total proposed budget supporting six counties in pursuing this Innovation Project is approximately $4.85M over 4.5-years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($2.87M), fiscal and contract management through CalMHSA ($.314M), third-party evaluation ($0.596M), as well as additional expenditures for county-specific needs ("County-Specific Costs") ($1.07M).

All costs will be funded using county MHSA Innovation funds, with the exception of San Mateo County which will contribute available one-time CSS funding. Counties will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs, which counties will manage and administer directly). This pooled funding approach will streamline counties' funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. See ***Figure 2*** below for the estimated total sources and uses of the project budget over the 4.5-year project duration across all six participating counties. The Appendix includes additional detail on each county's specific contributions and planned expenditures.

Budget Narrative for Shared Project Costs

Consultant Costs and Contracts: Each county is contributing funding to a shared pool of resources that will support the different contractor and consultant costs associated with the project. These costs include support from Third Sector (implementation TA), CalMHSA (fiscal and contract management), and the third-party evaluator (evaluation). These consultants and contractors will operate across the group of participating counties, in addition to supporting each individual county with its own unique support needs.

The total amount of consultant and contractor costs is approximately $3.78M across all six counties over the 4.5 year timeline. A description of each of these three cost categories follows below.

Third Sector Costs

As described in the *Project Activities and Deliverables* section above, Third Sector will lead counties through individualized implementation TA over a 23-month timeframe (January 2020 through November 2021). The total budget for Third Sector's TA across all six counties is $2.87M over the full 23-month TA period. These costs will fund Third Sector teams who will provide a wide range of dedicated technical assistance services and subject matter experience to each individual county, as they pursue the goals of this Innovation Plan. Third Sector staff will leverage regular site visits to each county, in addition to leading weekly to biweekly virtual meetings with different working groups, developing recommendations for the project Steering Committee, and supporting county staff throughout each of the three implementation TA phases.

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported over 20 communities to redirect over $800M

in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health to align over $350M in annual MHSA FSP and PEI funding and services with the achievement of meaningful life outcomes for well over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track each providers' monthly performance relative to others and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

CalMHSA Costs

Six counties (San Mateo, Sacramento, San Bernardino, Ventura, Siskiyou, and Fresno) have selected to contract using the existing Joint Powers Agreement (JPA) via CalMHSA. CalMHSA will act as the fiscal and contract manager for this shared pool of resources through the existing JPA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator. CalMHSA will develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties.

CalMHSA charges an estimated 9% for its services. Rates are based on the specific activities and responsibilities CalMHSA assumes. The total estimated cost of CalMHSA's services across all six counties, assuming a 9% rate, are $.314M over the total duration of the project.

Evaluation Costs

Third Sector and the counties will determine the appropriate procurement approach and qualifications for a third-party evaluator during the first nine months of the project. Counties have expressed a desire to prioritize onboarding an evaluator in the early stages of the project. Currently, counties have identified RAND Corporation as a potential evaluation partner, as RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in Los Angeles County. Once selected, counties intend to contract with the evaluator via the JPA administered through CalMHSA. Third Sector and CalMHSA will support counties in determining the appropriate statement of work, budget, and funding plan for the third-party evaluator.

The current budget projects a total evaluation cost of approximately $.596M. The evaluator will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing an evaluation report. Estimated costs assume that the counties, Third Sector, and the to-be-determined third-party evaluator will collaborate to develop a uniform evaluation approach and set of performance metrics, with corresponding metric definitions that can be applied consistently across all counties. Costs are estimates and subject to change. Additional charges, such as academic overhead rates and/or the costs for completing any required data sharing agreements, may apply. If any additional information emerges that will increase costs beyond the initially budgeted amounts, the counties, CalMHSA and Third Sector will work in partnership with the MHSOAC to identify appropriate additional funding.

Budget Narrative for County-Specific Costs

The remaining project costs are intended to support additional, county-specific expenditures. Counties will fund these costs directly, rather than through a pooled funding approach. A summary of the total $1.07M in County-Specific Costs across all six counties follows below. The Appendix includes additional detail of each county's specific expenditures within these categories:

Personnel Costs

Total personnel costs (county staff salaries, benefits) for all counties are approximately $844,000 over 4.5 years and across six counties. Each county's appendix, attached, details the specific personnel that this will support.

Operating Costs

Total operating costs for counties are approximately $233,000 over 4.5 years and across six counties. Operating costs support anticipated travel costs for each county and requisite county-specific administrative costs. Each county's appendix, attached, details their specific operating costs.

Non-Recurring Costs

This project will not require any technology, equipment, or other forms of non-recurring costs.

NOTE: Cohort 2 and its expansion will follow a similar budget structure. See Appendix B and Appendix C for details.

***Figure 2**: Cohort 1 Budget by Funding Source & Fiscal Year*

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$116,271	$181,117	$187,502	$137,735	$128,071	$750,696
2	Direct Costs	$15,454	$26,614	$27,945	$10,323	$4,700	$85,036
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$20,390	$24,390	$24,390	$24,390	$12,390	$105,950
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$30,175	$53,683	$53,683	$53,683	$41,684	$232,908
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$487,424	$1,515,954	$681,278	$186,000	$0	$2,870,655
11b	Direct Costs (CalMHSA)	$34,502	$197,029	$72,085	$6,564	$4,687	$314,866
11c	Direct Costs (3rd Party Evaluator)	$10,417	$101,649	$101,649	$196,649	$186,232	$596,596
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$532,343	$1,814,632	$855,012	$389,213	$190,919	$3,782,117
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Direct Costs		$552,733	$1,839,022	$879,402	$413,603	$203,309	$3,888,067
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
Total Innovation Project Budget		**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$621,032	$1,617,209	$899,869	$393,991	$178,828	$3,710,929
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$360,044	$125,623	$938	$938	$551,744
6.	**Total Proposed Administration**	**$685,235**	**$1,977,253**	**$1,025,492**	**$394,929**	**$179,766**	**$4,262,673**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$10,417	$52,085	$52,085	$147,085	$136,668	$398,340
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$0	$49,564	$49,564	$49,564	$49,564	$198,256
6.	**Total Proposed Evaluation**	**$10,417**	**$101,649**	**$101,649**	**$196,649**	**$186,232**	**$596,596**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$631,449	$1,669,294	$951,954	$541,076	$315,496	$4,109,269
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
6.	**Total Proposed Expenditures**	**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**
*If "Other funding" is included, please explain.							

*San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. Estimated amounts are provided in the table above. These are one-time funds that have been designated and approved through a local community program planning process to meet

a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is committed to participating in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Innovation Plan Appendix A: Cohort 1

Appendix Overview

The following appendix contains specific details on the local context, local community planning process (including local review dates), and budget details for four of the six counties participating in the Multi-County FSP Innovation Project as Cohort 1:

1. Sacramento County
2. San Bernardino County
3. Siskiyou County
4. Ventura County

The other two participating counties, Fresno County and San Mateo County, are not included in this appendix for the following reasons:

5. Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project. This plan was approved by the MHSOAC.
6. San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is participating in the broader effort and thus is included here.

Budget summaries for both Fresno and San Mateo, however, are included for additional reference regarding the total budget across all counties.

Each county appendix describes the county-specific local need for this Multi-County FSP Innovation Project. Though there are slight differences among participating counties' in terms of highest priority and/or specificity of local need, the response to this local need will be similar among counties through the execution of the Innovation Plan.

Through this Innovation Project proposal, participating counties seek to engage in a statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Multi-County FSP Innovation Project plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow each participating county to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable participating counties to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation

- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

This project will also provide participating counties the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

In addition to outlining county-specific local need and community planning processes, each county appendix outlines a budget narrative and county budget request by fiscal year, with detail on specific budget categories.

Appendix: Sacramento County

County Contact and Specific Dates

- Primary County Contact: Julie Leung; leungj@saccounty.net; (916) 875-4044
- Date Proposal was posted for 30-day Public Review: November 18, 2019
- Date of Local Mental Health Board hearing: December 18, 2019
- Date of Board of Supervisors (BOS) approval: January 14, 2020

Description of the Local Need

Sacramento County has eight (8) FSP programs serving over 2,100 individuals annually. Each FSP serves a specific age range or focuses on a specific life domain. While a majority of the FSP programs serve transition-aged youth (18+), adults and older adults, one FSP serves older adults only, another one serves TAY only, and two serve all ages. Further, one serves Asian-Pacific Islanders, one serves pre-adjudicated youth and TAY, and two support individuals experiencing or at risk of homelessness. A new FSP serving TAY (18+), adults and older adults will be added to Sacramento County's FSP service array this fiscal year. This new FSP will utilize the evidence-based Strengths case management model.

While FSP programs provide the opportunity to better serve specific age and cultural groups who need a higher level of care, Sacramento County seeks to establish consistent FSP service guidelines, evaluate outcomes, and disseminate best practices across all FSP programs. Community members, staff, and clinicians have identified opportunities to strengthen the connection between client outcome goals and actual services received and provided by FSP programs. Providers and county department staff do not share a consistent, clear understanding of FSP service guidelines, and providers and peer agencies do not currently have a forum to meet regularly and share learnings and best practices or discuss opportunities. Overall, stakeholders would like to see FSP data used in an effective, responsive way that informs decision-making and improves service quality. Additionally, county staff would like to update inconsistent or outdated standards for referral, enrollment, and graduation.

Description of the Response to Local Need

Through this Innovation proposal, Sacramento County seeks to participate in the statewide initiative for the purpose of increasing counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow Sacramento County to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable Sacramento County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation

- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, life domain example: homelessness, unemployment, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

In addition, this project will provide Sacramento County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process includes participation from the Sacramento County Mental Health Steering Act (MHSA) Steering Committee, Mental Health Board, Board of Supervisors, community based organizations, consumers and family members and community members. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of the community. Since this process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The Multi-County FSP Innovation Project was introduced to stakeholders at the May 16, 2019 Mental Health Services Act Steering Committee meeting. Further, at the October 17, 2019 MHSA Steering Committee meeting, the Multi-County FSP Innovation Project was presented and discussed. The Steering Committee voted in full support of Sacramento County Division of Behavioral Health Services, opting into this project with Innovation funding.

At the October 17, 2019 MHSA Steering Committee meeting, 24 committee members were in attendance and 17 public members attended. The MHSA Steering Committee is comprised of one primary member and one alternate from the following groups: Sacramento County Mental Health Board; Sacramento County's Behavioral Health Director; three (3) Service Providers (Child, Adult, and Older Adult); Law Enforcement; Adult Protective Services/Senior and Adult Services; Education; Department of Human Assistance; Alcohol and Drug Services; Cultural Competence; Child Welfare; Primary Health; Public Health; Juvenile Court; Probation; Veterans; two (2) Transition Age Youth (TAY) Consumers; two (2) Adult Consumers; two (2) Older Adult Consumers; two (2) Family Members/Caregivers of Children age 0 – 17; two (2) Family Members/Caregivers of Adults age 18 – 59; two (2) Family Members/Caregivers of Older Adults age 60+; and one (1) Consumer At-large. Some members of the committee have volunteered to represent other multiple stakeholder interests including Veterans and Faith-based/Spirituality.

The Multi-County FSP Innovation Project was posted as an attachment to the MHSA Fiscal Year 2019-20 Annual Update from November 18 through December 18, 2019. The Mental Health Board conducted a Public Hearing on December 18, 2019, beginning at 6.00 p.m. at the Grantland L. Johnson Center for

Health and Human Services located at 7001A East Parkway, Sacramento, California 95823. No public comments regarding this Innovation Project were received. The plan was presented for Board of Supervisors approval on January 14, 2020.

County Budget Narrative

Sacramento County will contribute up to $500,000 over the 4.5-year project period to support this statewide project. As of this time, Sacramento County intends to use MHSA Innovation funding subject to reversion at the end of FY19-20 for the entirety of this contribution.

As detailed below, Sacramento County will pool funding with other counties to support consultant and contracting costs. This $500,000 will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	
3	Indirect Costs	$0	$0	$0	$0	$0	
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$48,594	$269,134	$91,990	$0	$0	$409,718
11b	Direct Costs (CalMHSA)	$5,252	$30,341	$11,147	$938	$936	$48,614

11c	Direct Costs (Evaluator)	$-	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
CONTRIBUTION TOTALS							
Individual County Contribution		$54,849	$312,943	$114,455	$8,876	$8,876	$500,000
Additional Funding for County-Specific Project Costs		$0	$0	$0	$0	$0	$0
Total County Funding Contribution		$54,849	$312,943	$114,455	$8,876	$8,876	$500,000

Appendix: San Bernardino County

County Contact and Specific Dates

- Primary County Contacts: Francesca Michaels Francesca.michaels@dbh.sbcounty.gov, 909-252-4018; Karen Cervantes, kcervantes@dbh.sbcounty.gov, 909-252-4068
- Date Proposal was posted for 30-day Public Review: November 27, 2019
- Date of Local Mental Health Board hearing: January 2, 2020
- Calendared date to appear before Board of Supervisors: June 9, 2020

Description of the Local Need

San Bernardino County Department of Behavioral Health is dedicated to including diverse consumers, family members, stakeholders, and community members in the planning and implementation of MHSA programs and services. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. It empowers community members to generate ideas, contribute to decision making, and partner with the county to improve behavioral health outcomes for all San Bernardino County residents. San Bernardino is committed to incorporating best practices in the planning processes that allow consumer and stakeholder partners to participate in meaningful discussions around critical behavioral health issues. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

San Bernardino County has eight (8) FSP programs serving an estimated three thousand-four hundred-fifty-eight (3,458) individuals annually. Two (2) of these assist underserved children and youth living with serious emotional disturbance; one (1) serves Transitional Age Youth (TAY); four (4) serve adults with serious mental illness, and one (1) program specifically focuses on older adult populations. In addition to San Bernardino County FSP programs targeting specific age ranges, the programs are designed to serve unique populations such as those experiencing homelessness, who may be involved in criminal or juvenile justice, individuals transitioning from institutional care facilities, and high frequency users of emergency psychiatric services and hospitalizations, however all programs provide full wraparound services to the consumer. The specificity and number of these FSP programs are both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographic groups, our county stakeholders express the desire to establish consistency in FSP service guidelines or disseminate best practices across county regions, programs, or while transferring FSP services from one county to another. San Bernardino County intends to focus this project on Adult Full Service Partnership programs.

Through public forums, community members have identified the need for consistency in FSP services across regions, programs, and counties to better serve and stabilize consumers moving from one geographic region or program to another. Consumers have also expressed interest in a standardized format for eligibility criteria and consistency in services that are offered and/or provided. Community members, FSP staff, and clinicians have also identified an opportunity for data collection to be better integrated with assessment and therapeutic activities.

Description of the Response to Local Need

Through this Innovation proposal, San Bernardino County seeks to participate in the statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage Adult FSP programs and services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow San Bernardino County to address current challenges and center FSP programs and services around meaningful outcomes for participants. Specifically, participating in this project and aligning with the identified priorities will enable San Bernardino County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified

In addition, this project will provide San Bernardino County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests including the Board of Supervisors, and the Behavioral Health Commission. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared with stakeholders during the following:

- Community Advisory Policy Committee (CPAC), July 18, 2019
- Asian Pacific Islander Awareness Subcommittee, September 13, 2019
- Santa Fe Social Club, September 16, 2019
- African American Awareness Subcommittee, September 16, 2019
- Yucca Valley One Stop TAY Center, September 16, 2019
- Native American Awareness Subcommittee, September 17, 2019

- Transitional Age Youth (TAY) Subcommittee, September 18, 2019
- Serenity Clubhouse, September 19, 2019
- Co-Occurring and Substance Abuse Subcommittee, September 19, 2019
- Consumer and Family Member Awareness Subcommittee, September 23, 2019
- Central Valley FUN Clubhouse, September 24, 2019
- Ontario One Stop TAY Center, September 25, 2019
- Latino Awareness Subcommittee, September 26, 2019
- Older Adult Awareness Subcommittee, September 26, 2019
- A Place to Go Clubhouse, September 26, 2019
- Amazing Place Clubhouse, September 27, 2019
- Victorville One Stop TAY Center, September 27, 2019
- 2nd and 4th District Advisory Committee, October 10, 2019
- Disability Awareness Subcommittee, October 15, 2019
- 1st District Advisory Committee, October 16, 2019
- Community Advisory Policy Committee, October 17, 2019
- LGBTQ Awareness Subcommittee, October 22, 2019
- Women Awareness Subcommittee, October 23, 2019

Stakeholder feedback received was in favor of the Multi-County FSP Innovation Project with **96% of stakeholders in support** of the project, 4% neutral, and 0% opposed. A draft plan will be publicly posted for a 30-day comment period tentatively beginning on November 27, 2019. No feedback was received. The Plan was presented before the San Bernardino County Behavioral Health Commission on January 2, 2020. San Bernardino County will request Board of Supervisors review and final approval in February or March of 2020 (following the MHSOAC's review and approval process).

County Budget Narrative

San Bernardino County requests to contribute a total of $979,634 in MHSA Innovation funds to support this project over the 4.5-year project duration. This funding is not currently subject to reversion. A portion of these funds ($386,222) will cover San Bernardino County-specific expenditures, while the remainder ($593,412) will go towards the shared pool of resources that counties will use to cover shared project costs (i.e. Third Sector TA; CalMHSA; third-party evaluation):

- ***Personnel Costs:*** Costs in this category include salaries and benefits for the time spent by .10 of the Innovation Program Manager as well .5 of the Program Specialist II who will be the lead on this project. Salaries and benefits include a 3% increase to allow for cost of living increases each year. Based on current rates for administrative costs, San Bernardino County will allocate $349,272 for 4.5 years of personnel costs.
- ***Operating Costs:*** Costs in this category include travel and administrative costs that will be incurred by staff traveling to meetings for this project. Additional operating costs anticipated include printing materials for community stakeholder meetings, meeting space costs, as well as incentives to encourage stakeholder participation is consistent and ongoing. San Bernardino County anticipates operating costs, including travel, up to $36,950 over the 4.5 years, or $7,390 per year, which may vary based on the number of staff traveling and the number of in-person meetings. Costs will also vary on the number of additional stakeholder meetings held.

- ***Consultant Costs:*** The remaining amount, $588,778, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs (CalMHSA), and evaluation. The evaluation total for San Bernardino County's contribution is $41,668 or 4% of the allocated budget.

  The budget totals includes 36% of the budget for personnel costs with the remaining 64% going to direct costs associated with the project including county operating costs and the consultant costs. Note that all of San Bernardino's funding contributions would come from MHSA Innovation funding. See the below tables for an estimated breakdown of budget expenditures and requested funds by fiscal year.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412

Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Direct Costs		$71,593	$377,851	$143,430	$18,745	$18,745	$630,362
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$137,380	$445,611	$213,224	$90,632	$92,789	$979,634
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs		$73,177	$75,150	$77,184	$79,277	$81,434	$386,222
Total County Funding Contribution		$137,380	$445,611	$213,224	$90,632	$92,789	$979,634

Appendix: Siskiyou County

County Contact and Specific Dates

The primary contact for Siskiyou County is:

Camy Rightmier
Email: crightmier@co.siskiyou.ca.us
Tel: 530-841-4281

Siskiyou County's local review dates are listed in the table below. More detail on Siskiyou's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 10, 2019
Local Mental Health Board Hearing	January 21, 2020
Board of Supervisors (BOS) approval	February 4, 2020

Description of Local Need

Siskiyou County operates two FSP programs, a Children's System of Care (CSOC) and an Adult System of Care (ASOC) program that combined serve approximately 230 individuals annually. Program eligibility is determined by diagnosis and risk factors pursuant to the MHSA regulations for FSP criteria. Each Partner is assigned a clinician and case manager that work in the appropriate system of care as determined by the Partner's age. FSP programs may also receive psychiatric services and/or peer support services upon referral by the primary service provider. Many Partners also receive services through the county Wellness Center.

Due to the specificity and flexibility of the FSP program, the county has encountered difficulty developing consistent FSP service guidelines, evaluating outcomes, and disseminating best practices. Siskiyou County utilizes the Data Collection Reporting (DCR) database developed by the State to track outcomes, however, this tool has not been useful with regard to informing treatment or promoting quality improvements.

Community stakeholders have consistently identified the need for clear, consistent and reliable data and outcomes to assist programs in identifying goals, measuring success and pinpointing areas that may need improvement. Throughout numerous focus groups where outcomes have been shared, the Department has recognized that consumers are not interested in the measurement of progress, rather they are solely focused on the amelioration of the problem. Therefore, Siskiyou County Behavioral Health rarely receives feedback on outcome data and is evaluating the program in order to find a meaningful way in which to share the data that will encourage collaborative feedback.

Conversations with Siskiyou County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff, and interpretation and implementation of these guidelines varies widely. Data is collected for compliance and does not inform decision-making or service quality improvements, and data is collected within one system, with limited knowledge of cross-agency outcomes. Further, standards for referral, enrollment, and graduation are inconsistent, outdated, or non-existent.

Response to Local Need

Through this Innovation proposal, Siskiyou County Behavioral Health seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Siskiyou County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Siskiyou County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Siskiyou County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Board, providers, consumers, community members and partners. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in stakeholder groups in March 2019, where the proposed use of Innovation funds was well-received. A draft plan was posted for a 30-day comment period beginning on December 10, 2019. No comments were received during the public comment period. Siskiyou presented this plan at a public hearing with the local mental health board on January 21, 2020. Siskiyou County submitted a

final plan (incorporating any additional feedback received) to its Board of Supervisors for review and approval on February 4, 2020.

County Budget Narrative

Siskiyou County will contribute up to $700,000 of MHSA Innovation Funds over the 4.5-year project period to support this statewide project. As of this time, Siskiyou County does not intend to use funding subject to reversion for this contribution. As detailed below, Siskiyou County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Siskiyou County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs*: Siskiyou County anticipates travel costs up to $16,000 over the 4.5 years, or approximately $3,500 per year, which may vary based on the number of staff traveling and the number of in-person convenings. Including estimated administrative costs, Siskiyou County will allocate approximately $178,000 for 4.5 years of personnel costs.
- *Shared Project Costs*: The remaining amount, $506,000, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and third-party evaluation support

Siskiyou County Budget Request and Expenditures by Fiscal Year

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$17,578	$35,616	$37,396	$7,771	$7,771	$106,132
2	Direct Costs	$10,597	$21,514	$22,590	$4,700	$4,700	$64,101
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**Total**
5	Direct Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0

Consultant Costs/Contracts (training, facilitation, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11a	Direct Costs (Third Sector)*	$58,353	$100,000	$61,983	$0	$0	$220,336
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,252
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$105,417	$105,417	$231,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Direct Costs		$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Indirect Costs		$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Total Individual County Innovation Budget*		$95,787	$207,741	$151,573	$123,450	$121,450	$700,001
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Additional Funding for County-Specific Project Costs		$31,584	$63,986	$66,985	$17,095	$15,095	$194,745
Total County Funding Contribution		$95,787	$207,741	$151,573	$123,450	$121,450	$700,001

* Third Sector will provide additional support and capacity to Siskiyou County, beyond the amount Siskiyou is able to contribute using county Innovation dollars alone. This is intended to support the objectives of Third Sector's contract with the Commission, i.e. that this Multi-County FSP Innovation Project make effort to support and provide meaningful capacity to counties with limited financial resources to participate in the project.

Appendix: Ventura County

County Contact and Specific Dates

The primary contacts for Ventura County are:

Kiran Sahota
Email: kiran.sahota@ventura.org
Tel: (805) 981-2262

Hilary Carson
Email: hilary.carson@ventura.org
Tel: (805) 981-8496

Ventura County's local review dates are listed in the table below. More detail on Ventura's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 17, 2019
Local Mental Health Board Hearing	January 27, 2020
Board of Supervisors (BOS) approval	March 10, 2020

Description of Local Need

Ventura County has 7 FSP programs serving 619 individuals in the 2018/19 fiscal year. Each of these programs has a specific focus, yet they overlap in the age groupings as compared to age groupings as prescribed by MHSA regulations. One (1) of these serves juveniles currently on probation, 1 of these programs serves transition age youth, 4 serve adults age 18 years and older, and another serves older adults. The majority of these programs focus on individuals who are currently experiencing or at risk of experiencing incarceration, substance abuse, or homelessness. Eligibility is determined by the following factors: experience or at risk of incarceration, substance abuse, homelessness, hospitalization, or removal from the home, as well as the individual's age and a case manager or clinician recommendation.

The specificity and number of these FSP programs is both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographical groups, our county often struggles to establish consistent FSP service guidelines, evaluate outcomes, or disseminate best practices.

A common, recurring theme at community engagement gatherings has resonated toward offering more concentrated care for the seriously and persistently mentally ill homeless population. Along this line, Ventura County conducted a Mental Health Needs Assessment recently that indicated a need to address issues of homelessness and dual diagnosis as priority populations. Ventura County FSP services are fewer for those under 18 years of age and with respect to ethnicity. There has been consistent communication in Santa Paula and Oxnard community meetings to stress the need to increase services in breadth and depth to the Latinx community. A more cohesive suite of services for step up and step

down crisis aversion. To this end, Ventura County has opened up two Crisis Stabilization Units in the past two years however the feedback continues to be that there is need for more to be done.

Conversations with Ventura County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff—interpretation and implementation of these guidelines varies widely. Further, there is not a standard documented model of care designed for each FSP age grouping (Youth, TAY, Adult, Older Adult). FSP has a different meaning and objectives within each group, but is not formally documented. As age categories are further documented, identifying the idiosyncratic challenges particular to each target group due to the needs being very different.

Staff and clinicians have also indicated that data is collected for state mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, but outcomes are designed to be measured with cross-agency data collection systems (such as health care, criminal justice, etc.) meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources. Providers and peer agencies do not have a forum to meet regularly and share learnings and best practices or discuss opportunities. Standards for referral, enrollment, and graduation are inconsistent or outdated. Finally, there is a need for more clarity in the understanding of FSP funding allowances. The “whatever it takes” category is especially open to interpretation and there’s no standard across counties to compare approved expenditures or to know what resources are available through FSP funds

Response to Local Need

Through this Innovation proposal, Ventura County seeks to participate in the statewide initiative to increase counties’ collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Ventura County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Ventura County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Ventura County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, and community members. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in the following Behavioral Health Advisory Board subcommittee meetings:

- Adult Committee on Thursday, November 7, 2019
- Executive Meeting on Tuesday, November 12, 2019
- Prevention Committee on Tuesday, November 12, 2019
- Youth & Family Committee on Wednesday, November 13, 2019
- TAY Committee on Thursday, November 21, 2019
- General Meeting on Monday, November 18, 2019

This project was shared as a part of the 3 year-plan update in the section of proposed use of Innovation funds. A more detailed draft plan proposal was posted for a 30-day public comment period beginning on December 16, 2019. The Behavioral Health Advisory Board held a public hearing on the proposed plan on January 27, 2020. The plan will be revised based on any feedback received, after which it is scheduled to go before the Ventura County Board of Supervisors for review and final approval on March 10, 2020.

County Budget Narrative

Ventura County will contribute $979,634 using MHSA Innovation funds over the 4.5-year project period to support this statewide project. As of this time, Ventura County intends to use funding subject to reversion at the end of FY 19-20 for the entirety of this contribution.

As detailed below, Ventura County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Ventura County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs:* Ventura County anticipates travel costs up to $13,000 over the 4 years, or $3,000 per year, which may vary based on the number of staff traveling and the number of in-person convening's. Based on current rates for administrative costs, Ventura County will allocate $296,801 for 4 years of personnel costs. The following positions have been allocated at a few hours annually over the next few years in order to achieve the project goals of system change.
    - Senior Project Manager
    - Program Administrator
    - Quality Assurance Administrator

- Electronic Health Record System Coordinator
- Behavioral Health Clinician

- *Shared Project Costs:* The remaining amount, $593,412 will support project management and technical assistance (e.g., Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

County Budget Request by Fiscal Year

The table below depicts Ventura County's year-over-year contribution to the Multi-County FSP Innovation Project.

County Budget Request and Expenditures by Fiscal Year and Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
2	Direct Costs						
3	Indirect Costs						
4	Total Personnel Costs	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$1,000	$3,000	$3,000	$3,000	$3,000	$13,000
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$10,785	$32,293	$32,293	$32,293	$32,294	$139,958
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668

12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Direct Costs		$65,203	$373,461	$139,040	$14,355	$14,355	$606,412
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
Total Individual County Innovation Budget*		$96,519	$468,551	$236,104	$88,557	$89,905	$979,634
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs		$32,316	$98,090	$100,064	$77,202	$78,550	$386,222
Total County Funding Contribution		$96,519	$468,551	$236,104	$88,557	$89,905	$979,634

Appendix: Fresno County Budget Tables

As mentioned above, Fresno County submitted an Innovation Project proposal to the MHSOAC in June 2019, detailing Fresno's participation in this project. This plan has been approved by the commission and thus. Additional appendix detail on local need is not included here as this information is more comprehensively outlined in Fresno's Innovation Plan proposal.

A summary of Fresno's approved budget follows below. Note that the approved Fresno County budget includes costs for Third Sector, CalMHSA and the third-party evaluation in a single total under "Other Project Expenditures"), approximately $840,000 total over the 4.5 years.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
Fresno County Funding Contribution	$237,500	$237,500	$237,500	$237,500	$0	$950,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$11,375	$11,944	$12,541	$13,168	$0	$49,028
2	Direct Costs	$4,857	$5,100	$5,355	$5,623	$0	$20,935
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$16,232	$17,044	$17,896	$18,791	$0	$69,963
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11	Direct Costs	$0	$0	$0	$0	$0	$0
12	Indirect Costs	$0	$0	$0	$0	$0	$0

13	Total Consultant Costs	$0	$0	$0	$0	$0	$0
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$221,685	$210,456	$209,604	$198,292	$0	$840,037
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$221,685	$210,456	$209,604	$198,292	$0	$840,037
BUDGET TOTALS							
Personnel		$11,375	$11,944	$12,541	$13,168	$0	$49,028
Direct Costs		$14,857	$15,100	$15,355	$15,623	$0	$60,935
Indirect Costs		$221,685	$210,456	$209,604	$198,292	$0	$840,037
Total Individual County Innovation Budget*		$247,917	$237,500	$237,500	$227,083	$0	$950,000

Appendix: San Mateo County Budget Tables

As noted above, San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local Community Program Planning (CPP) process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project.

Local Community Planning Process

On October 2, 2019, the San Mateo County MHSA Steering Committee reviewed a "Plan to Spend" one-time available funds, developed from input received through the following:

- The previous MHSA Three-Year Plan CPP process - 32 community input sessions
- Behavioral Health and Recovery Services budget planning - 3 stakeholder meetings
- Additional targeted input sessions to further involve community-based agencies, peers, clients and family members in the development of the Plan to Spend including:
    - MHSARC Older Adult Committee – June 5, 2019
    - MHSARC Adult Committee – June 19, 2019
    - MHSARC Youth Committee – June 19, 2019
    - Contractor's Association – June 20, 2019
    - Office of Consumer and Family Affairs/Lived Experience Workgroup – July 2, 2019
    - Peer Recovery Collaborative – August 26, 2019

The Plan to Spend included $500,000 to better align San Mateo'sSan Mateo's FSP programming with BHRS goals/values and improve data collection and reporting. The proposed Multi-County FSP Innovation Project was brought forward as the means to accomplish this goal. San Mateo's local mental health board, the Mental Health and Substance Abuse and Recovery Commission (MHSARC), reviewed the Plan to Spend and on November 6, 2019 held a public hearing, reviewed comments received and voted to close the 30-day public comment period. The Plan to Spend was subsequently approved by the San Mateo County Board of Supervisors on April 7, 2020. The Plan to Spend also included $250,000 for any ongoing needs related to FSP program improvements. San Mateo has brought forward the proposed Multi-County FSP Innovation Project as the means to accomplish this longer-term goal. The update to the Plan to Spend will be included in the current San Mateo County FY 2020-2023 Three-Year Plan and Annual Update, which will be brought to the San Mateo County Board of Supervisors for approval, likely in August 2020. San Mateo is not submitting a proposal to use INN funds. Detailed appendix information is thus not included below, though a summary of San Mateo's intended funding amounts and expenditures follows below. Note that, like other counties, these amounts are subject to change and further local input and approval.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
San Mateo County Funding Contribution	$500,000	$250,000	$0	$0	$0	$750,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$49,564	$49,564	$49,564	$49,564	$198,256
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$64,203	$409,608	$175,187	$50,502	$50,502	$750,000

Indirect Costs	$0	$0	$0	$0	$0	$0
Total Individual County Budget*	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000

Innovation Plan Appendix B: Cohort 2

Appendix Overview

The following appendix contains specific details on the local context, local community planning process, and budget details for the two counties participating in the Multi-County FSP Innovation Project as Cohort 2:

1. Stanislaus County
2. Lake County

Each county appendix describes the county-specific need for this Multi-County FSP Innovation Project. Though there can be slight differences among participating counties' needs in terms of either the prioritization or the specifics, the response to this local need will be similar among counties through the execution of the Innovation Plan. Each county appendix also outlines a county-specific budget narrative and budget request by fiscal year, with detail on specific budget categories.

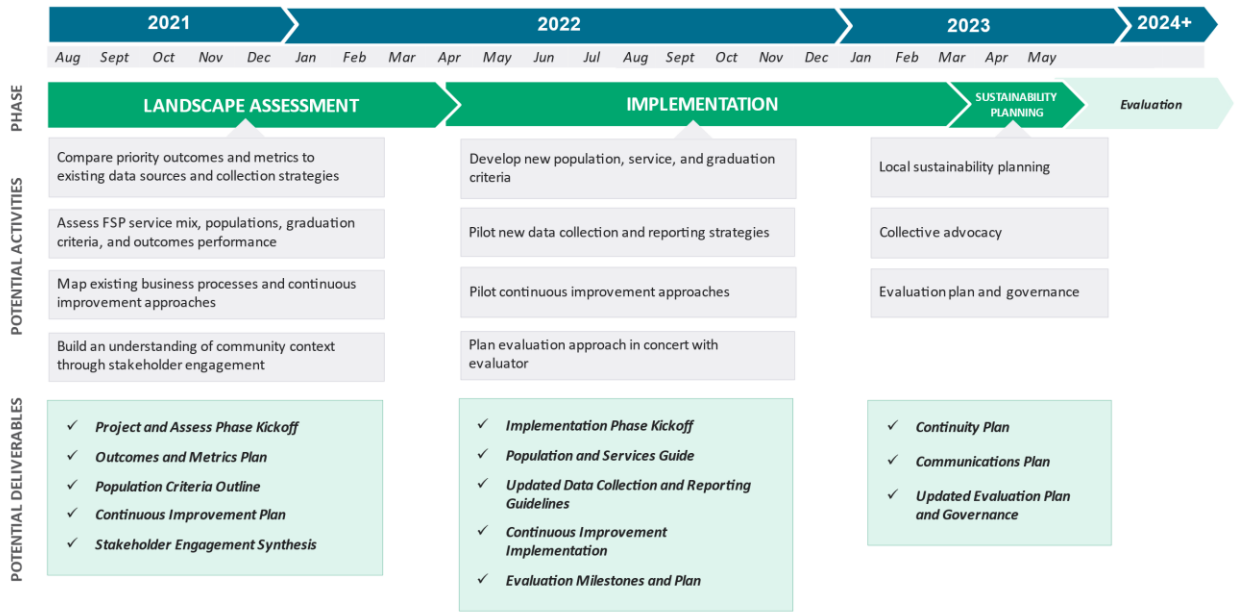
Work Plan and Timeline

Cohort 2 counties will join the Multi-County FSP Innovation Project in August 2021 and follow a similar work plan and timeline as the original six counties over the course of the subsequent 4.5 years. See ***Figure 3*** below for an illustrative Implementation TA work plan and timeline by phase.

While some adjustments in process and structure may occur to fit the unique needs of the next cohort, the goals of the project will remain consistent:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

Figure 3: Cohort 2 Illustrative Implementation TA Work Plan



Benefits of Project Expansion

The addition of the Cohort 2 counties to the Multi-County FSP Innovation Project will grow the impact of the project across the state. The current six counties are developing a more consistent, data-driven approach to FSP that includes standardizing population definitions, process measures, and outcomes, as well as creating recommendations to improve the Data Collection & Reporting System (DCR). Cohort 2 counties will not only be able to adopt the work done to- date but will also be able to build upon the work with a fresh perspective. Examples may include:

- Adding child population definitions, process measures, and outcomes to the existing list of adult definitions and measures developed by Cohort 1
- Furthering the efforts to update the DCR by continuing to work with counties across the state and DHCS on potential improvements.

Cohort 2 will benefit the state by both expanding on current initiatives and by increasing the resources available to other counties statewide by adding more 'tools to the toolkit.'

Another benefit of growing the Innovation Project is the expansion of knowledge sharing across counties. In addition to joining the cohort-wide work done to date, Cohort 2 counties will also be focusing on several county-specific implementation initiatives to create lasting improvements within their individual FSP programs. By joining the existing project, new counties will be able to leverage best practices and lessons learned from the six counties that have already begun local implementation. For example, if Stanislaus County determines they need to standardize their local graduation criteria across programs, they will benefit from the five other counties that have already gone through this process. In turn, Cohort 1 counties will also be able to apply any new learnings from Cohort 2 counties through their continuous improvement structures.

All of these learnings will also be shared across the state through the Outcomes-Driven FSP Learning Community, a forum for County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders to help increase statewide consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines. Third Sector is supporting the first several Learning Communities with the intention for the long-term forum to be largely county-driven and county-led. The addition of Cohort 2 counties means there will be more individuals available to coordinate, plan, and facilitate future Learning Communities in order to continue engagement statewide.

Finally, Cohort 2 counties will be added to the existing project evaluation, creating a broader understanding of the impact of direct technical assistance, highlighting additional learnings and benefits of a multi-county collaborative, and driving consistent data collection and analyses across all participating counties. While the current six counties are incorporating equitable data practices and working to disaggregate data by race, Cohort 2 counties will be able to further these efforts. For example:

- Stanislaus County will be incorporating a Human Centered Design (HCD) approach into their stakeholder engagement in order to ensure all initiatives are co-developed by the community.
- Lake County, with a population of 65,000, will be the second frontier county to join the collaborative, further elevating the voice and unique needs of rural county populations and systems of care.

Ultimately, the addition of Cohort 2 counties will bring California one step closer to having consistent data to compare FSP programs and outcomes in a meaningful and equitable way and share best practices statewide through regular collaborative forums.

Budget Narrative

The total proposed budget supporting Cohort 2 counties in pursuing this Innovation Project, which includes Stanislaus County and Lake County, is approximately $2.5M over 4.5 years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($1.43M), fiscal and contract management through CalMHSA ($151K), third-party evaluation ($250K), as well as additional expenditures for county-specific needs (“County-Specific Costs”) ($680K).

All costs will be funded using county MHSA Innovation funds. If multiple counties join, each county will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs, which counties will manage and administer directly). This pooled funding approach will streamline counties’ funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. The Appendix includes additional detail on each county’s specific contributions and planned expenditures.

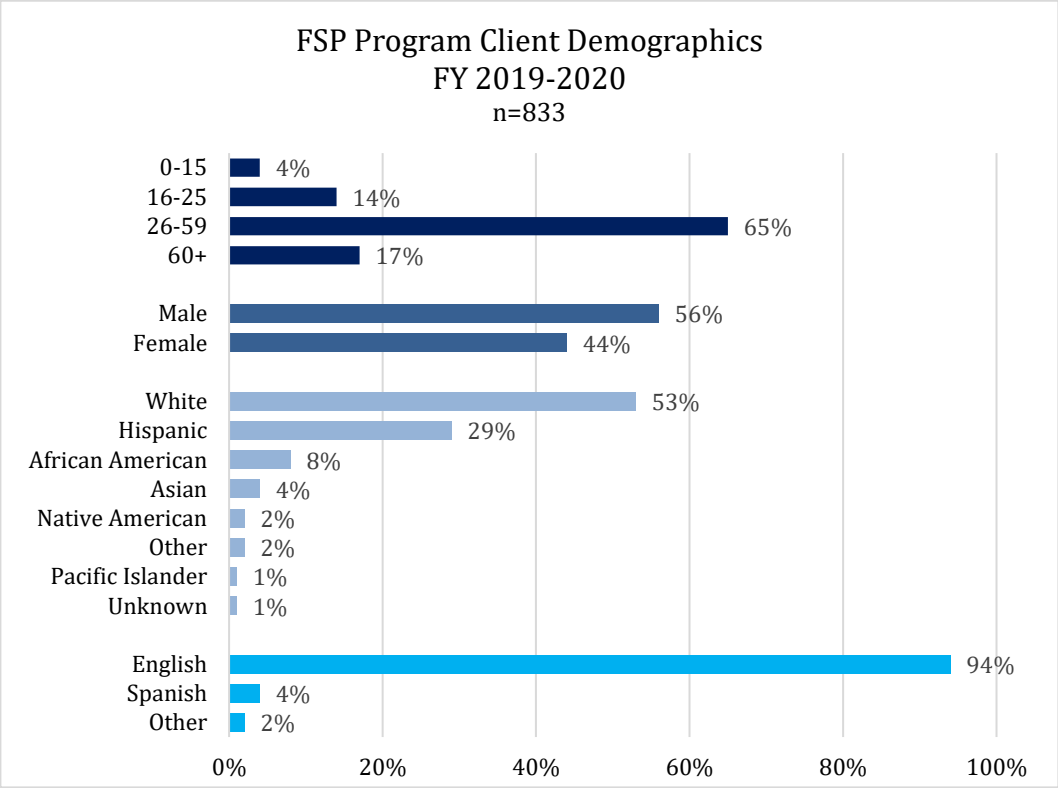
Appendix: Stanislaus County

County Contact and Specific Dates

- Martha Cisneros Campos, mcisneros@stanbhrs.org, 209-525-5324
  Kirsten Jasek-Rysdahl, KJasek-Rysdahl@stanbhrs.org, 209-525-6085
- Date Proposal posted for 30-day Public Review: April 21, 2021
- Date of Local MH Board hearing: May 27, 2021
- Date of BOS approval or calendared date to appear before BOS: June 15, 2021

Description of the Local Need

Stanislaus County Behavioral Health and Recovery Services (BHRS) currently has eight Full Service Partnership (FSP) programs, and during FY 2019-2020 these programs served a total of 833 clients. The client demographics illustrate the populations that are receiving the majority of FSP program services, but it is not clear if this reflects the current needs of Stanislaus County.



Although these clients represent some of the most underserved or unserved community members, it has been over a decade since BHRS implemented FSP programs by utilizing a comprehensive and thorough approach to explore the demographic and individual needs of Stanislaus County's FSP population. Since we are dedicated to continuously evaluate what is working well and what could be improved in our FSP programs, BHRS has recently engaged the community to update and further

understand and address the unique challenges and needs of our FSP clients. We plan to leverage this engagement and apply a human-centered design (HCD) approach through this Innovation Project. In addition, BHRS recognizes the need to share outcomes with our stakeholders to both inform and elicit feedback from the community. Stakeholders have expressed strong interest in improving FSP program data and better understand program outcomes.

BHRS has identified the need and desire to use and share meaningful data in a clear and engaging way to better understand if our FSP programs are truly resulting in positive recovery outcomes for the clients served. This also includes reviewing ways to improve where we are less successful, e.g., exploring ways that BHRS can be more responsive to individuals' needs, and to better coordinate with other community partners. BHRS overarching goals for this project are reflected below:

- More clearly identify priority outcomes for FSP clients
- Develop effective data collection and tracking mechanisms to increase the accuracy and meaning of FSP data for transforming into performance measures and outcomes
- Create an FSP framework and practices that foster continuous improvement of outcomes for FSP clients
- Develop sustainable ways to continuously evaluate how BHRS FSP programs are effectively meeting the community needs

In recent years, BHRS staff have explored ways to improve data collection, analysis, presentation, and use of data to be more outcome oriented and data-driven, but there are multiple issues and challenges that affect our ability to meet our overarching goals:

- Consistent and accurate data collection by staff is challenging.
    - Staff are focused on quality care and it is often difficult to elicit buy-in for the importance of entering and utilizing client data regularly when using the DCR and other databases is time consuming.
    - Data collection tools can be confusing or frustrating for staff.
- Extracting, analyzing, presenting, and interpreting/creating meaning from data requires skilled staff and time.
- Utilizing data consistently for improvement requires monitoring and resources committed to that practice.
- Stakeholders have multiple perspectives about what data and outcomes are meaningful, and how to use this information.
- Data-driven decisions regarding program design/revisions can be difficult to implement and sustain.

Since BHRS internal resources are limited as described above, this Innovation Project will provide the support and shared learning necessary to fulfill the goals outlined above.

Description of the Response to the Local Need

The proposed Innovation Project will address Stanislaus County BHRS' FSP program challenges and needs through a thorough and inclusive approach. The project will support BHRS in implementing

improvements in how we design, provide, and continuously improve FSP programs in the following ways:

- Create shared understanding of current FSP programs – who the programs are serving, how they are serving them, and what data is being collected to yield outcome measurement
- Include stakeholders in the identification of FSP program strengths and areas of improvement
- Identify problem statements that can be used to create FSP programs that are data and outcome oriented
- Develop and support data collection, analysis, and presentation processes that allow BHRS to identify disparities through demographics and outcomes data, as well as ensure individual clients are connected to appropriate and customized services to increase positive outcomes
- Identify and define FSP program outcome goals, and develop meaningful performance measures to track progress towards goals; concurrently develop sustainable processes for using the data for continuous tracking and improvement
- Clarify, streamline, and improve design and practices within FSP programs to better serve our County's FSP population and subpopulations
- Leverage other counties' processes, learning, and best practices while participating in the Multi-County FSP Innovation Project

Ultimately, this project will help BHRS meet the overarching goals of identifying priority outcomes for FSP clients, developing effective data collection techniques and ongoing measurement, creating an effective FSP framework to improve FSP client outcomes, and developing a structure for continuous evaluation of how well BHRS FSP programs are meeting community needs.

Cultural & Linguistic Competency

Based on the Department of Finance January 2020 population estimates, Stanislaus County has 557,709 residents, of which 45.6% reported Hispanic/Latino; 42.6% reported White; 5.3% reported Asian; 2.6% reported Black; 2.5% reported Two or more races (not Hispanic/Latino); .7% Native Hawaiian or Pacific Islander; .5% reported American Indian and Alaska Native; and .2% reported Other Race (not Hispanic/Latino).

Although diverse, Stanislaus County currently has one threshold language of Spanish. BHRS county staff consist of approximately 25% Spanish speaking staff. In addition, we have staff that speak other languages such as; Cambodian, Assyrian, Hindi, and many other languages. When programs are unable to have a staff person assist in translation, programs utilize our contracted translators (including American Sign Language) or connect with Language Line.

BHRS is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. To ensure we continue to improve the quality of services and eliminate inequities and barriers to care for marginalized cultural and ethnic communities, BHRS supports the Cultural Competence, Equity, and Social Justice Committee (CCESJC). The committee consists of program providers, consumers, family members, and communities representing all cultures and meets monthly to discuss cultural and linguistic needs of our county. Our Cultural Competence and Ethnic Services Manager chairs the committee and ensures the county behavioral health systems are culturally and linguistically competent and responsive in the delivery of behavioral health services. This innovation

project will support the cultural and linguistic needs of the county through a better understanding of the client needs.

Description of the Local Community Planning Process

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the Covid-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of MHSA regulations and their specific role as it relates to the community planning process for the three-year plan and annual update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020 was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with innovation projects already approved. BHRS quickly observed that two multicounty collaborative innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole and one aligned well with BHRS efforts to create a more robust stakeholder process for future innovations.

To explore this further and to ensure stakeholder support on these innovation projects, BHRS conducted an information session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The information session for proposed innovations was a dedicated meeting for proposed innovations on December 29th. Following the December 29th innovation information session stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with all three proposed innovations.

Proposed projects will go formally to the Stanislaus County Board of Supervisors (BOS) on June 15, 2021. Following formal approval by the BOS the projects will go through the review period with the MHSOAC as well be posted for the 30-Day local review period for the public.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Total County Contribution to Collaborative	412,729	838,017	330,999	175,401		1,757,146

BUDGET NARRATIVE FOR COUNTY SPECIFIC NEEDS:

Personnel

The total personnel cost for the county portion is $648,035 over four years. This includes $386,574 for salaries and $261,461 for fringe benefits.

Personnel will include a 0.5 FTE Software Developer/Analyst III and a 0.5 FTE Staff Services Coordinator for four years.

These two positions will provide the following support to contribute to the success of this Innovation Project.

Staff Services Coordinator will:

- Oversee and act as liaison to the Innovation Project contractors
- Coordinate and facilitate meetings and discussions amongst Innovation Project contractors, partners, and other stakeholders
- Coordinate internal staff and project partners to ensure the necessary assignments are completed to meet project requirements, timelines, and quality expectations
- Develop and monitor project timelines; provide updates/status of projects to stakeholders as appropriate
- Oversee, coordinate, and provide technical assistance for the data collection, analysis and reporting of the performance measures for this Innovation Project
- Provide training and technical assistance related to project data and results to staff and stakeholders

Software Developer/Analyst III will:

- Help identify the appropriate county-level data and data transfer methods
- Extract county-level data from the electronic health record, DCR, and other program databases and sources; de-identify data before transferring to contracted staff
- Identify problems and possible solutions in the county-level data (e.g., issues with available data or methods)
- Participate in all relevant meetings regarding data for this Innovation Project

The personnel costs include a 3% annual increase to include cost-of-living salary increases and the associated retirement, and FICA increases based on the increased salaries as well as increases for health care costs.

Operating Costs

The ongoing operating costs total $24,560 over four years. This includes cell phones, office supplies, copier costs, computer licenses, MiFi service for laptops, utilities, alarm and security costs, zoom subscriptions, telephone and data processing services, and janitorial costs.

Nonrecurring Costs

Nonrecurring costs total $10,900 for equipment for the set-up of the office for the two staff members. This includes, desks, chairs, computers, laptops, and software.

Consultant Costs/Contracts

The budget includes $1,073,651 for contracted services over three years. This includes $810,000 for Third Sector, $88,651 for CalMHSA, and $175,000 for RAND as the Evaluator.

The total budget over four years is $1,757,146.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS

EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)							
1.	Salaries	154,898	159,545	164,331	169,261		648,035
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	154,898	159,545	164,331	169,261		648,035
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	6,140	6,140	6,140	6,140		24,560
6.	Indirect Costs						
7.	Total Operating Costs	6,140	6,140	6,140	6,140		24,560
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8	Desk, Chair, Computer, Laptop	9,900					9,900
9.	Software	1,000					1,000
10.	Total Non-recurring Costs	10,900					10,900

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Third Sector)	210,909	559,091	40,000			810,000
11b.	Direct Costs (CalMHSA)	19,882	55,514	13,255			88,651
11c.	Direct Costs (RAND)	10,000	57,727	107,273			175,000
12.	Indirect Costs						
13.	Total Consultant Costs	240,791	672,332	160,528			1,073,651
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		154,898	159,545	164,331	169,261	-	648,035
Direct Costs (add lines 2, 5 and 11 from above)		246,931	678,472	166,668	6,140	-	1,098,211
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-Recurring costs (line 10)		10,900					10,900
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		412,729	838,017	330,999	175,401		**1,757,146**

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**

1.	Innovative MHSA Funds	402,729	780,290	223,726	175,401		1,582,146
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Administration**	402,729	780,290	223,726	175,401		1,582,146
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	10,000	57,727	107,273			175,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Evaluation**	10,000	57,727	107,273			175,000
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	412,729	838,017	330,999	175,401		1,757,146
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Expenditures**	**412,729**	**838,017**	**330,999**	**175,401**		**1,757,146**

Appendix: Lake County

County Contact and Specific Dates

The primary contact for Lake County is:

Scott Abbott
Email: scott.abbott@lakecountyca.gov
Tel: 707-274-9101

Lake County Behavioral Health Services' (LCBHS) local review dates are listed in the table below. More detail on Lake's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review *No public comment was received during this time*	June 22, 2021
Local Mental Health Board Hearing approval	July 22, 2021
Board of Supervisors (BOS), calendared date to appear before BOS	September 14, 2021

Description of Local Need

Lake County operates four Full Service Partnership (FSP) programs: Children's, Transitional Age Youth, Adult, and Older Adult programs that combine to serve approximately 120 individuals annually. Program eligibility is determined by diagnosis and risk factors pursuant to the Mental Health Service Act (MHSA) regulations for FSP criteria. Each Partner is assigned a clinician and case manager that work in the appropriate program as determined by the Partner's age receiving treatment services such as case management and linkages, rehabilitation, therapy, and ongoing assessment and plan development. FSPs may also receive psychiatric services and/or housing support services upon referral by the primary service provider. Many Partners also receive services through the peer support centers around the county.

Due to the specificity and flexibility of the FSP program, the county has encountered difficulty developing consistent FSP service guidelines, evaluating outcomes, and disseminating best practices. Lake County utilizes the Data Collection Reporting (DCR) database developed by the State to track outcomes, however, due to a variety of systematic and technical challenges the DCR has limited utility for informing treatment decisions or promoting quality improvements.

LCBHS management and community stakeholders have consistently identified the need for clear, consistent and reliable data and outcomes to assist programs in identifying goals, measuring success and pinpointing areas that may need improvement. Though outcome measurements are desired, up until recently LCBHS has rarely received program feedback based on quantitative outcome data and has relied on qualitative data and reports obtained from the Electronic Health Record. Conversations with Lake County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs.

LCBHS is seeking to establish, identify, and define clear guidelines ("guardrails") for each step in a client's journey through FSP to support decision making and provide clients with a clear vision for their experience in the program, while retaining the flexible "whatever it takes" FSP philosophy. Historically, ambiguity around these steps has resulted in confusion and unexpected challenges for clinicians and clients, and made it difficult to manage the program with a data-driven approach. For example, without clear standards for engagement, LCBHS has struggled to set targets for regular contact with clients that are tailored to the client's needs and stage of recovery. If these targets were in place and informed by relevant outcomes data on an ongoing basis, LCBHS would be able to more effectively allocate clinician and case worker time to meet clients "where they are" while focusing resources where they are needed most. Similarly, clear standards for graduation from FSP would give clients a long-term goal to work towards, while facilitating more consistent, tailored services as clients progress in their recovery.

Response to Local Need

Through this Innovation proposal, Lake County Behavioral Health Services seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Lake County Behavioral Health Services to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Lake County Behavioral Health Services the opportunity to share and exchange knowledge with other counties participating in this project and through the statewide learning community.

Local Community Planning Process

The community planning process helps Lake County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, community-based organizations, consumers, community members and partners. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in a large quarterly MHSA stakeholder meeting on April 15, 2021 with over 37 virtual participants. After the presentation of the local needs assessment and a review of this proposed

use of innovation funds, stakeholders acknowledged the project as an appropriate use of funding. The project was also shared in the MHSA Fiscal Year 2020 – 21 Annual Update and at the quarterly Innovations Steering Committee on June 17, 2021.

A draft plan was publicly posted for a 30-day comment period beginning on June 22, 2021 and no public comments were received. In addition, the plan was presented at the Lake County Mental Health Board Hearing on July 22, 2021 and approved. The plan is scheduled to go before the Lake County Board of Supervisors for review and final approval on September 14, 2021 (following the MHSOAC's review process).

County Budget Narrative

Lake County will contribute up to $765,000 over the 4.5-year project period to support this statewide project. As detailed below, Lake County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Lake County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs*: Lake County anticipates travel costs up to $7,450 over the 4.5 years, which may vary annually based on the number of staff traveling and the number of in-person convenings.

- *Shared Project Costs*: The remaining amount, $757,500 will support project management and technical assistance (e.g., Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

Total Budget Request by Fiscal Year

The table below depicts Lake County's year-over-year contribution to the Innovation Project.

Table 1

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	Total
Individual County Contribution to the Collaborative*	$339,390	$339,390	$28,740	$28,740	$28,740	$765,000

Budget by Fiscal Year and Specific Budget Category

Table 2

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
1.	Salaries	$0	$0	$0	$0	$0	$0
2.	Direct Costs	$0	$0	$0	$0	$0	$0
3.	Indirect Costs	$0	$0	$0	$0	$0	$0
4.	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
5.	Direct Costs	$1,490	$1,490	$1,490	$1,490	$1,490	$7,450
6.	Indirect Costs	$0	$0	$0	$0	$0	$0
7.	Total Operating Costs	$1,490	$1,490	$1,490	$1,490	$1,490	$7,450
Non-Recurring Costs (technology, equipment)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
8.	Direct Costs	$0	$0	$0	$0	$0	$0
9.	Indirect Costs	$0	$0	$0	$0	$0	$0
10.	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
11a.	Direct Costs (Third Sector)	$310,000	$310,000	$0	$0	$0	$620,000
11b.	Direct Costs (CalMHSA)	$27,900	$27,900	$2,250	$2,250	$2,250	$62,550
11c.	Direct Costs (Evaluator)	$0	$0	$25,000	$25,000	$25,000	$75,000
12.	Indirect Costs	$0	$0	$0	$0	$0	$0
13.	Total Consultant Costs	$337,900	$337,900	$27,250	$27,250	$27,250	$757,550
Other Expenditures (explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
14.	Program/Project Cost	$0	$0	$0	$0	$0	$0
15.		$0	$0	$0	$0	$0	$0
16.	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$339,390	$339,390	$28,740	$28,740	$28,740	$765,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget		$339,390	$339,390	$28,740	$28,740	$28,740	$765,000

Innovation Plan Appendix C: Cohort 2 Expansion

Appendix Overview

The following appendix contains specific details on the local context, local community planning process, and budget details for Napa County participating in the Multi-County FSP Innovation Project as an expansion to Cohort 2.

The appendix describes the county-specific need for this Multi-County FSP Innovation Project. Though there can be slight differences among participating counties' needs in terms of either the prioritization or the specifics, the response to this local need will be similar among counties through the execution of the Innovation Plan. The appendix also outlines a county-specific budget narrative and budget request by fiscal year, with detail on specific budget categories.

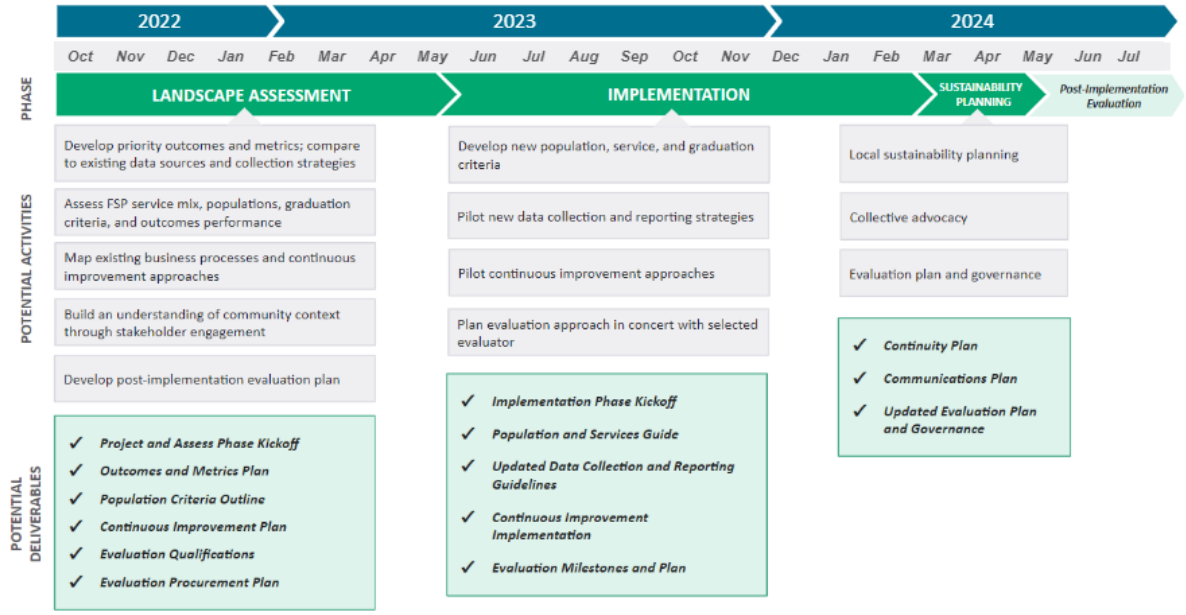
Work Plan and Timeline

Napa County will join the Multi-County FSP Innovation Project in October 2022 and follow a similar work plan and timeline as the other Wave 2 counties, Lake and Stanislaus, over the course of the subsequent 4.5 years. See ***Figure 3*** below for an illustrative Implementation TA work plan and timeline by phase.

While some adjustments in process and structure may occur to fit the unique needs of joining the project at this time, the goals of the project will remain consistent:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, and how next steps and program modifications are identified)

Figure 3: Cohort 2 Expansion Illustrative Implementation TA Work Plan



Benefits of Project Expansion

The addition of Napa County to the Multi-County FSP Innovation Project as an expansion of Cohort 2 will continue to grow the impact of the project across the state. The current counties are developing a more consistent, data-driven approach to FSP that includes standardizing population definitions, process measures, and outcomes. Napa County will not only be able to adopt the work done to date but will also be able to build upon the work alongside Lake and Stanislaus counties. Examples may include:

- Adding child population definitions, process measures, and outcomes to the existing list of adult definitions and measures developed by Cohort 1
- Furthering the efforts to update the DCR by continuing to work with counties across the state and DHCS on potential improvements

The expansion of Cohort 2 will benefit the state by building on current initiatives and by increasing the resources available to other counties statewide by adding more 'tools to the toolkit.'

Another benefit of growing the Innovation Project is the expansion of knowledge sharing across counties. In addition to joining the cohort-wide work done to date, Cohort 2 counties will also focus on several county-specific implementation initiatives to create lasting improvements within their individual FSP programs. By joining the existing project, new counties can leverage best practices and lessons learned from the counties that have already begun local implementation. For example, if Napa County determines they need to standardize their local graduation criteria across programs, they will benefit from the five other counties that have already gone through this process. In turn, Cohort 1 counties will also be able to apply any new learnings from Cohort 2 counties through their continuous improvement structures.

All of these learnings will also be shared across the state through the Outcomes-Driven FSP Learning Community, a forum for County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders to help increase statewide consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines. Third Sector is supporting the first several Learning Communities with the intention for the long-term forum to be largely county-driven and county-led. The addition of Napa County means more individuals will be available to coordinate, plan, and facilitate future Learning Communities to continue engagement statewide.

Finally, Napa County will be added to the existing project evaluation, creating a broader understanding of the impact of direct technical assistance, highlighting additional learnings and benefits of a multi-county collaborative, and driving consistent data collection and analyses across all participating counties. While the current six counties are incorporating equitable data practices and working to disaggregate data by race, Cohort 2 counties will be able to further these efforts.

Ultimately, the addition of another Cohort 2 county will bring California one step closer to having consistent data to compare FSP programs and outcomes in a meaningful and equitable way and share best practices statewide through regular collaborative forums.

Budget Narrative

The total proposed budget supporting Napa County is approximately $844,750 over 4.5 years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($650,000), fiscal and contract management through CalMHSA ($69,750), and third-party evaluation ($125K). All costs will be funded using county MHSA Innovation funds.

Appendix: Napa County

County Contact and Specific Dates

- Primary County Contact: Felix Bedolla, MHSA Coordinator, Felix.Bedolla@countyofnapa.org
- Date Proposal posted for 30-day Public Review: Friday, July 8 – Monday, August 8, 2022
- Date of Local MH Board hearing: Monday, August 8, 2022
- Date of BOS approval or calendared date to appear before BOS: Tuesday, September 13, 2022

Description of Local Need

FSP Program Overview: Napa County has five Full Service Partnership (FSP) programs. During FY 2020-2021, these programs served a total of 249 consumers served, including 54 children served by Children's FSP, 35 youth served by Transition Age Youth (TAY) FSP, 73 adults served by Adult FSP, 34 adults served by the Adult Treatment Team (ATT) FSP, and 53 older adults served by Older Adult (OA) FSP. Individuals who identified as White, 46%, were the highest represented group. Hispanic/Latinos were the second largest group receiving services, 27% of individuals identified as Hispanic/Latino. Only 1% of individuals identified as Native American, and under 1% identified as Mixed, making both of these groups the least represented. Napa county FSP programs provided 4,105 aggregate services in FY20-21. The service provided most frequently was intensive care coordination and individual therapy. The services least provided were DBT group rehab intervention, TCM placement service, and court-related activity.

FSP Challenges: Local stakeholders have identified a number of challenges that could be addressed through the Multi-County FSP Innovation Project.

- **Telling the Story of FSP's Impact:** Local stakeholders have asked the MH Division to provide evaluation data to demonstrate the effectiveness of FSP services. They point out that the MH Division requires contractors to evaluate their own programs, and they have expressed strong interest in reviewing FSP evaluation data; however, the following issues have made it difficult to paint an accurate picture of the impact of the FSP services provided by Napa County staff.
- **Data collection, reporting, and training challenges:** Napa County has reported outcomes for the individuals served by the previously mentioned FSPs in the California Department of Health Care Services Data Collection and Reporting (DCR) System. In the early years of MHSA implementation, staff were able to extract meaningful data from the system and generate accurate FSP outcome reports; however, as time went on unresolved DCR issues made it difficult to impossible to extract useful and meaningful data from the DCR System. Additionally, limited training opportunities for FSP staff have contributed to lack of understanding around how to make best use of the DCR system. FSP staff are committed to providing high-quality care for their FSP partners and focus on completing progress notes for our Electronic Health Record (EHR). Unfortunately, staff are not as consistent entering data into the DCR and neglect to complete Key Event Tracking or 3M Quarterly Forms because it is separate data entry process and their priorities are focused on documentation of the services they provide to ensure they are maintaining productivity standards.
- **Lack of Clear Definitions of Discharge Reasons:** When compiling FSP outcomes to report in the FY 21-22 Annual Update, staff determined that FSP programs each have their own understandings and reasons for selecting "Administrative and NA" as the reason for discharge. A significant number of cases were closed under these discharge reasons; however, it is difficult to identify or track a standard for this discharge. Through participation in the FSP Collaborative,

staff hope to work with FSP staff to create shared definitions for discharge reasons and identify cases and scenarios when these reasons are applicable, and share best practices.

- **Staff Turnover and Outliers:** The MH Division has experienced significant staff turnover throughout the years and some staff have left abruptly without reassigning partners to other staff or closing partners who are no longer receiving services. As a result of this situation, there are outliers in the DCR that skew the outcome results and don't present an accurate picture of the true outcomes of the FSP programs. Efforts to resolve these outliers with DCR Technical Assistance have been unsuccessful and so these outliers continue to skew outcomes and invalidate outcome reports.

Response to Local Need

Through this Innovation proposal, Napa County Behavioral Health Services seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Napa County Behavioral Health Services to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Develop training materials for staff and supervisors to support increased accuracy in the completion of DCR Outcome reports and forms.
3. Develop FSP Outcome and Audit reports that accurately reflect the impact FSP services are having on FSP partners
4. Create a model of best practices that is relevant for the current needs of FSP partners in the age of Covid, housing challenges, etc.
5. Incorporate learnings for other cohorts participating in the Multi-County FSP Collaborative to improve services and practices in Napa County FSPs
6. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals are discussed, what data is included and in what format, and how next steps and program modifications are identified).

In addition, this project will provide Napa County Behavioral Health Services the opportunity to share and exchange knowledge with other counties participating in this project and through the statewide learning community.

Local Community Planning Process

As was previously mentioned, stakeholders have been requesting accountability through meaningful evaluation reports for the County's FSP programs. Staff presented this proposal to participate in the Multi-County FSP Collaborative to the Stakeholder Advisory Committee on April 6th, 2022. This proposal was well-received by Stakeholders, who were supportive of the goal of being able to tell the story of the impact of FSP services on community members receiving services.

The Stakeholder Advisory Committee (SAC) has been active in all stages of the MHSA planning since 2006, when the committee was convened to develop and guide implementation of MHSA Components and programs. The SAC has been meeting monthly since that time to share information, changes and updates regarding MHSA Components and programs as well as other Mental Health Division services

and plans. Participants work with NCMH to ensure that their constituencies receive the information necessary to be able to give input and participate in the planning process. SAC meetings take place every first Wednesday of the month and meetings are open to the public.

Although the SAC is the most involved in the planning process, other groups also have the opportunity to participate. MHSA information is distributed to MH Division staff, the Napa County MH Board, MHSA Contractors, community mental health providers, and the Behavioral Health Cultural Competence Committee.

Public review and public hearing

The 30-day Public Review and Comment Period for the FY 22-23 Annual Update to the MHSA Three Year Plan is took place from Friday, July 8th to Monday, August 8th, with a public hearing held via Zoom at a publicly noticed meeting of the Napa County Mental Health Board on Monday, August 8th at 4pm. No public comments were received relating to the Multi-County FSP Innovation Project; therefore, there was nothing to address following the Public Review and Comment Period.

Budget Narrative

Napa County will contribute up to $844,750 over the 4.5-year project period to support this statewide project. This amount will support project management and technical assistance provided by Third Sector, fiscal intermediary costs, and evaluation provided by RAND.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 22/23	FY 23/24	FY 24/25	TOTAL
Total Napa County Contribution to Collaborative	332,450	428,733	83,567	844,750

Consultant Costs/Contracts

The budget includes $844,750 for contracted services over three years. This includes $650,000 for Third Sector, $69,750 for CalMHSA (9% of Third Sector and RAND costs), and $125,000 for RAND as the Evaluator. The total budget over four years is $844,750.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY-SPECIFIC NEEDS

EXPENDITURES						
PERSONNEL COSTS (salaries, wages, benefits)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	0	0	0	0	0
2.	Direct Costs					
3.	Indirect Costs					

4.	Total Personnel Costs	0	0	0	0	0
OPERATING COSTS		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	0	0	0	0	0
6.	Indirect Costs					
7.	Total Operating Costs	0	0	0	0	0
NONRECURRING COSTS (equipment, technology)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8.	Desk, Chair, Computer, Laptop	0	0	0	0	0
9.	Software	0	0	0	0	0
10.	Total Non-recurring Costs	0	0	0	0	0

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Third Sector)	295,000	355,000	0	0	650,000
11b.	Direct Costs (CalMHSA)	27,450	35,400	6,900	0	69,750
11c.	Direct Costs (RAND)	10,000	38,333	76,667	0	125,000
12.	Indirect Costs	0	0	0	0	
13.	Total Consultant Costs	332,450	428,733	83,567	0	844,750
OTHER EXPENDITURES (please explain in budget narrative)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.		0	0	0	0	0
15.		0	0	0	0	0
16.	Total Other Expenditures	0	0	0	0	0
BUDGET TOTALS						
Personnel (line 1)		0	0	0	0	0
Direct Costs (add lines 2, 5 and 11 from above)		332450	428733	83,567	0	844,750

Indirect Costs (add lines 3, 6 and 12 from above)	0	0	0	0	0
Non-Recurring costs (line 10)	0	0	0	0	0
Other expenditures (line 16)					
TOTAL INNOVATION BUDGET	332,450	428,733	83,567	0	844,750

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
ADMINISTRATION:						
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	332,450	390,400	6,900	0	**719,750**
2.	Federal Financial Participation	0	0	0	0	0
3.	1991 Realignment	0	0	0	0	0
4.	Behavioral Health Subaccount	0	0	0	0	0
5.	Other Funding	0	0	0	0	0
6.	**Total Proposed Administration**	322,450	390,400	6,900	0	**719,750**
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	10,000	38,333	76,667	0	**125,000**
2.	Federal Financial Participation					
3.	1991 Realignment					

4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Evaluation**	10,000	38,333	76,667	0	**125,000**
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	332,450	428,733	83,567	0	**844,750**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Expenditures**	332,450	428,733	83,567	0	**844,750**

STAFF ANALYSIS—NAPA County

Innovation (INN) Project Name:	**Full-Service Partnership Multi-County Collaborative**
Total INN Funding Requested:	**$844,750**
Duration of INN Project:	**4.5 Years**
MHSOAC consideration of INN Project:	**October 2022**

Review History:

Approved by the County Board of Supervisors:	September 13, 2022
Mental Health Board Hearing:	August 8, 2022
Public Comment Period:	July 8, 2022-August 8, 2022
County submitted INN Project:	August 1, 2022
Date Project Shared with Community Partners:	August 11, 2022 and September 2, 2022

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to introduce a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

This Proposed Project meets INN criteria by increasing the quality of mental health services, including measured outcomes, and promotes interagency and community collaboration related to Mental Health Servies supports or outcomes.

Project Introduction:

Napa County is requesting up to $844,750 of Innovation spending authority to join the Full-Service Partnership (FSP) Multi-County Collaborative for existing specific FSP programs, originally approved by the Commission starting with Fresno County on June 25, 2019.

What is the Problem?

Full-Service Partnerships (FSP) falls within the Community Services and Supports (CSS) component of the MHSA. Being one of the three CSS components, the FSP service is an integrated, "whatever it takes" combination of community-based, voluntary services and strategies, built around the needs and goals of mental health consumers themselves. The core goals of these programs are to improve wellness and reduce the negative outcomes associated with severe mental illness (SMI) through active partnership between clients and their service providers.

FSPs also represents the greatest single program expenditure category and serve the populations with the highest needs in the community. Each County is required to allocate 80% of its MHSA funds to CSS programs and 51% of that is required to be specifically allocated to FSPs. Yet, despite this large expenditure for MHSA programs, there is no statewide effort to develop and implement best practices for FSP programs, and no clear model for data collection or analysis. The FSP Multi-County Collaborative will provide answers for data collection and clarity/guidelines for service programs.

The FSP Multi-County Collaborative consists of two Cohorts (8 total counties): Cohort one includes Fresno, Sacramento, San Mateo, San Bernardino, Siskiyou and Ventura Counties and Cohort two includes Stanislaus and Lake County, with Napa County joining the Cohort Two (2) Expansion. Fresno was the first County to seek approval for the FSP Multi-County Collaborative in the amount of $950,000, obtaining Commission approval on June 19, 2019. Four counties (Sacramento, San Bernardino, Siskiyou, Ventura) were approved on June 5, 2020, and Stanislaus joined on June 24, 2021, with a Commission approved contribution of $1,757,146 and Lake County received approval on November 2, 2021, for $765,000. Ventura County requested an extension, and the Commission approved an additional $702,227 on March 3, 2022, for a total of $7,333,642 in approved innovation funding. San Mateo County is also participating in the FSP collaborative without utilizing innovation funds, contributing to the project with CSS funding in the amount of $593,412.

The Commission contracted with Third Sector who worked collaboratively with the above Counties by administratively guiding counties through the development and implementation of this project and support the use of Innovation funds to develop the foundation for FSP service programs by utilizing data driven strategies and evaluation to better coordinate and increase quality of services and improve outcomes.

Napa County currently offers five FSP programs including Children's, Transition Age Youth (TAY), Adults, Adult Treatment Team (ATT) and Older Adults, that collectively served 249 consumers in Fiscal Year 2020-2021.

Local Community Partners asked the Mental Health division to provide evaluation data to demonstrate the effectiveness of FSP services.

The County has encountered difficulty in accurately extracting useful and meaningful data from the DCR system, including:

- **Discharge reasons that do not reflect an accurate explanation for the discharge**
  - **Discharge definitions are inconsistent**
  - **Administrative and N/A discharge are overutilized**
- **Staff turnover contributes to skewed DCR outcome results**
  - **Abrupt staff resignations occur without continuity of care considerations in place**
- **Consistent staffing has been unsuccessful, skewing outcomes and invalidating outcome reports**

Napa County proposes to invest in this FSP Innovation to improve program data sharing, program outcomes, and implementation of learning to improve quality and inclusiveness of efficacious FSP services. The program will allow the county to evaluate current local services and their success, while addressing uncovered challenges, and identify needs for program improvement, accurate date documentation, consistent programmatic definition, and improved outcome measures.

The Community Program Planning Process (CPPP) (pages 72-73)

Local Level

Napa County's Community Partners have consistently requested accountability through meaningful evaluation reports for the County's FSP programs. The Advisory Committee met on April 6, 2022, and provided support to move Napa County's participation in the Full-Service Partnership Multi-County Collaborative forward with the goal of telling the story of the impact of consumers receiving FSP services.

Commission Level

Commission staff originally shared this project with its six Community contractors and the listserv on August 11, 2022, while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with Community Partners on September 2, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

There were no comments received in response to the Commission sharing the plan with Community Partners, contractors, Committees and the listserv.

Learning Objectives and Evaluation:

To guide their project; the counties have identified several learning questions that are centered on both systems-level and client level outcomes. These learning questions include:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collections and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have the staff learnings though participation in this FSP-focused project led to shared learning across other programs and services within each participating county?
6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the outcomes-driven FSP learning community and collective group of participating counties?
8. Which types of collaborative forums and topics have yielded the greatest value for county participants?
9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Napa County's specific goals for this project:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Develop training materials for staff and supervisors to support increased accuracy in the completion of DCR Outcome reports and forms.
3. Develop FSP Outcome and Adult reports that accurately reflect the impact FSP services are having on FSP partners.
4. Create a model of best practices that is relevant for the current needs of FSP partners in the age of COVID, housing challenges, etc.
5. Incorporate learnings for other cohorts participating in the Multi-County FSP Collaborative to improve services and practices in Napa County FSPs.
6. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals are discussed, what data is included and in what format, and how next steps and program modifications are identified).

In addition, this project will provide Napa County Behavioral Health Services the opportunity to share and exchange knowledge with other counties participating in this project through the statewide learning community.

The Budget

County	Total INN Approved Funding	Duration of INN Project
Fresno	$950,000	4
Sacramento	$500,000	4.5
San Bernardino	$979,634	4.5
Siskiyou	$700,001	4.5
Ventura	$979,634	4.5
Ventura (Extension)	$702,227	No Time Added
Stanislaus	$1,757,146	4.5
Lake	$765,000	4.5
Total:	**$7,333,642**	

**San Mateo County is participating utilizing CSS funding.*

County	Direct Costs	Third Sector	CalMHSA	Total
Napa	**$125,000**	**$650,000**	**$69,750**	**$844,750**

The total INN investment for 9 counties participating in the FSP Collaborative with this funding will be $8,178,392

Comments:

Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021) Full-Service Partnership Authorizes the Commission to publicly report outcomes for people receiving community mental health services under a Full-Service Partnership (FPS) model and **to develop recommendations to strengthen the use of FSPs to reduce incarceration, hospitalization, and homelessness**.

The FSP Multi-County Collaborative will contribute to this work and continue to improve services that are consistent with this legislation.

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

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the August Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 0.00
21MHSOAC023	$ 0.00
Total	**$ 0.00**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,858,431.78**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **1,858,431.78**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/21 - 06/30/24

Total Contract Amount: $5,414,545.00

Total Spent: **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Not Started	12/31/2022	No
Quarterly Progress Reports	Not Started	03/31/2023	No
Quarterly Progress Reports	Not Started	06/30/2023	No

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	09/30/2023	No
Quarterly Progress Reports	Not Started	12/31/2023	No
Quarterly Progress Reports	Not Started	03/31/2024	No
Quarterly Progress Reports	Not Started	06/30/2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

OCTOBER 2022

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	4	9	**13**
Participating Counties (unduplicated)	4	8	**12**
Dollars Requested	$12,293,270.54	$70,064,886	**$82,358,156.54**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023	1	1	$844,750	1

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Santa Cruz	Healing The Streets	$5,735,209	5 Years	12/9/2021	Pending
Under Review	Orange	Clinical High Risk for Psychosis in Youth	$13,000,000	5 Years	2/26/2022	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	Pending
Under Review	Shasta	Hope Park (Extension)	$104,760	N/A	6/17/2022	Pending
Under Review	Alameda	Peer-led Continuum for Forensics and Reentry Services	$8,615,531	5 Years	7/25/2022	Pending
Under Review	Alameda	Alternatives to Confinement	$13,432,653	5 Years	7/25/2022	Pending
Under Review	Tuolumne	Family Ties: Youth and Family Wellness	$217,953	5 Years	8/22/2022	Pending
Under Review	Santa Barbara	Housing Retention and Benefit Acquisition	$8,076,389	5 Years	9/8/2022	Pending
Under Review	Santa Clara	TGE Center	$17,298,034	54 Months	10/4/2022	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Sonoma	Semi-Statewide Enterprise Health Record	$4,420,447.54	5 Years	9/16/2022	9/27/2022
Under Final Review	Tulare	Semi-Statewide Enterprise Health Record	$6,281,021	5 Years	9/16/2022	9/27/2022
Under Final Review	Humboldt	Semi-Statewide Enterprise Health Record	$608,678	5 Years	9/16/2022	9/27/2022

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Colusa	Practical Actions Towards Health (PATH) – EXTENSION (formerly called Social Determinants of Rural Mental Health)	$983,124	5 Years	8/8/2022	9/20/2022

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date
Napa	FSP Multi-County Collaborative	$844,750	10/11/2022

DHCS Status Chart of County RERs Received
October 27, 2022, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated October 3, 2022. This Status Report covers FY 2019 -2020 through FY 2020-2021, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2020-2021 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2020-21 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DHCS Status Chart of County RERs Received
October 27, 2022, Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Alameda	1/29/2021	2/1/2021	2/8/2021	1/26/2022	2/3/2022	2/8/2022
Alpine	7/1/2021		10/15/2021	1/26/2022	2/3/2022	2/15/2022
Amador	1/15/2021	1/15/2021	2/2/2021	1/27/2022	2/3/2022	2/10/2022
Berkeley City	1/13/2021	1/13/2021	1/13/2021	2/1/2022	2/3/2022	3/1/2022
Butte	3/2/2022	3/2/2022	3/11/2022	8/11/2022	8/12/2022	8/15/2022
Calaveras	1/31/2021	2/1/2021	2/9/2021	1/31/2022	2/4/2022	2/8/2022
Colusa	4/15/2021	4/19/2021	5/27/2021	2/1/2022	2/4/2022	2/15/2022
Contra Costa	1/30/2021	2/1/2021	2/22/2021	1/31/2022	2/4/2022	3/11/2022
Del Norte	2/1/2021	2/2/2021	2/17/2021	1/28/2022	2/7/2022	2/23/2022
El Dorado	1/29/2021	1/29/2021	2/4/2021	1/28/2022	2/4/2022	2/9/2022
Fresno	12/29/2020	12/29/2021	1/26/2021	1/26/2022	2/7/2022	2/16/2022
Glenn	2/19/2021	2/24/2021	3/11/2021	3/21/2022	3/22/2022	4/6/2022
Humboldt	4/9/2021	4/13/2021	4/15/2021	8/15/2022	8/16/2022	8/24/2022
Imperial	2/1/2021	2/1/2021	2/12/2021	1/31/2022	2/4/2022	2/15/2022
Inyo	4/1/2021	4/2/2021		4/1/2022	4/12/2022	
Kern	2/2/2021	2/2/2021	2/8/2021	2/3/2022	2/7/2022	2/17/2022
Kings	1/4/2021	1/4/2021	3/11/2021	2/22/2022	2/22/2022	3/11/2022
Lake	2/9/2021	2/9/2021	2/17/2021	2/1/2022	2/8/2022	2/23/2022
Lassen	1/25/2021	1/25/2021	1/28/2021	2/2/2022	2/8/2022	2/17/2022
Los Angeles	3/11/2021	3/16/2021	3/30/2021	2/1/2022	2/7/2022	2/22/2022
Madera	3/29/2021	3/30/2021	4/15/2021	3/25/2022	3/29/2022	5/19/2022
Marin	2/2/2021	2/2/2021	2/17/2021	1/31/2022	2/7/2022	2/9/2022
Mariposa	1/29/2021	1/29/2021	3/11/2021	1/31/2022	2/7/2022	2/25/2022
Mendocino	12/30/2020	1/4/2021	1/20/2021	2/1/2022	2/7/2022	2/24/2022

DHCS Status Chart of County RERs Received
October 27, 2022, Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Merced	1/11/2021	1/12/2021	1/15/2021	1/27/2022	2/7/2022	2/8/2022
Modoc	4/29/2021	5/4/2021	5/13/2021	4/27/2022	4/28/2022	4/28/2022
Mono	1/29/2021	1/29/2021	2/16/2021	1/18/2022	2/7/2022	2/17/2022
Monterey	2/24/2021	3/1/2021	3/11/2021	2/2/2022	2/7/2022	2/9/2022
Napa	12/23/2020	12/24/2020	12/28/2020	2/7/2022	2/8/2022	3/3/2022
Nevada	1/29/2021	2/16/2021	2/18/2021	1/31/2022	2/2/2022	2/3/2022
Orange	12/31/2020	1/20/2021	2/9/2021	1/31/2022	2/3/2022	2/17/2022
Placer	2/3/2021	2/22/2021	2/23/2021	1/31/2022	3/17/2022	4/13/2022
Plumas	2/25/2021	3/19/2021	3/25/2021	7/14/2022	7/14/2022	
Riverside	2/1/2021	3/31/2021	4/8/2021	1/31/2022	2/4/2022	3/11/2022
Sacramento	1/29/2021	2/1/2021	5/6/2021	1/31/2022	2/3/2022	3/11/2022
San Benito	7/28/2021	7/30/2021	8/3/2021			
San Bernardino	3/3/2021	3/4/2021	3/17/2021	3/23/2022	3/23/2022	3/29/2022
San Diego	1/30/2021	2/1/2021	2/4/2021	1/31/2022	2/3/2022	2/18/2022
San Francisco	1/29/2021	3/19/2021	3/22/2021	1/31/2022		2/4/2022
San Joaquin	2/1/2021	2/2/2021	2/11/2021	3/22/2022	3/23/2022	3/25/2022
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021	1/26/2022	2/2/2022	2/7/2022
San Mateo	1/29/2021	2/1/2021	2/16/2021	1/31/2022	8/3/2022	8/4/2022
Santa Barbara	12/29/2020	12/30/2020	1/5/2021	1/26/2022	1/26/2022	2/10/2022
Santa Clara	1/28/2021	2/11/2021	3/3/2021	1/31/2022	2/15/20222	2/18/2022
Santa Cruz	3/29/2021	4/5/2021	4/15/2021	3/25/2022	3/25/2022	4/4/2022
Shasta	1/14/2021	1/15/2021	1/19/2021	1/25/2022	1/26/2022	2/10/2022
Sierra	12/31/2020	3/10/2021	4/12/2021	1/31/2022	2/2/2022	2/28/2022
Siskiyou	2/16/2021	6/11/2021	6/15/2021	7/18/2022	7/18/2022	8/10/2022
Solano	2/1/2021	2/1/2021	2/25/2021	1/31/2022	2/2/2022	2/8/2022
Sonoma	1/29/2021	3/5/2021	4/12/2021	1/31/2022	2/3/2022	2/22/2022

DHCS Status Chart of County RERs Received
October 27, 2022, Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Stanislaus	12/31/2020	1/5/2021	1/5/2021	1/31/2022	2/2/2022	2/15/2022
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021	2/9/2022	2/10/2022	2/15/2022
Tehama	4/27/2021	n/a	5/21/2021			
Tri-City	1/27/2021	3/4/2021	3/30/2021	1/31/2022	2/2/2022	5/25/2022
Trinity	2/1/2021	2/2/2021	2/17/2021	7/5/2022	7/5/2022	7/27/2022
Tulare	1/26/2021	1/27/2021	2/10/2021	1/31/2022	2/2/2022	2/10/2022
Tuolumne	6/2/2021	8/11/2021	8/11/2021	1/31/2022		2/4/2022
Ventura	1/29/2021	2/2/2021	2/16/2021	1/28/2022	2/2/2022	2/14/2022
Yolo	1/28/2021	2/2/2021	2/2/2021	1/31/2022	2/2/2022	2/2/2022
Total	**59**	**57**	**58**	**57**	**55**	**55**

Mental Health Services
Oversight & Accountability Commission

Tentative Upcoming MHSOAC Meetings and Events

Updated 10/10/2022

NOVEMBER 2022

- 11/8: Children's Committee Meeting
  - 9:00AM – 12:00PM
  - Public

- 11/10: Cultural and Linguistic Competency Committee Meeting
  - 3:00PM – 5:00PM
  - Public

- 11/15: Client and Family Leadership Committee Meeting
  - 1:00PM – 3:00PM
  - Public

- 11/17: November Commission Meeting
  - 9:00AM – 1:00PM
  - Public

DECEMBER 2022

- No Commission Meeting