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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting
May 23, 2024
9:00 AM – 4:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

May 23, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on May 23, 2024, 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, 11123.5, 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	May 23, 2024
TIME	9:00 a.m.
LOCATION	1812 9th Street Sacramento, CA 95811

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZYtduupqDwuGdRIM1sFygVX-qX-5VT4tVcI

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

- Champion vision into action to increase public understanding of services that address unmet mental health needs.
- Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.
- Inspire innovation and learning to close the gap between what can be done and what must be done.
- Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

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 a.m. **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 a.m. **2. Announcements and Updates**

Information

Chair Mara Madrigal-Weiss, Commissioners, and staff will make announcements and updates.

9:30 a.m. **3. General Public Comment**

Information

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

9:50 a.m. **4. April 25, 2024 Meeting Minutes**

Action

The Commission will consider approval of the minutes from the April 25, 2024 Commission Meeting.

- Public Comment
- Vote

10:00 a.m. **5. Transformational Change in Behavioral Health: Full-Service Partnerships Panel**

Action

The Commission will receive an update on the Full-Service Partnership project, including recent efforts to drive improvements in service delivery and partner outcomes; *facilitated by Kallie Clark, PhD, Research Scientist Supervisor; panelists:*

Tyler Sadwith, State Medicaid Director, Department of Health Care Services (amended 5/16/2024)
Emily Melnick, Director, Third Sector;
~~*Jason Pace, Senior Associate, Third Sector;*~~ *(amended 5/16/2024)*
~~*Rose Waltz-Peters, Manager, Third Sector;*~~ *(amended 5/16/2024)*
Richard Johnson, CEO, Healthy Brains Global Initiative;
Jonathan Sherin, Chief Medical Officer, Healthy Brains Global Initiative;
Susan Holt, Behavioral Health Director, Fresno County.

- Public Comment
- Vote

12:00 p.m. **6. Lunch**

12:45 p.m. **7. Innovation Proposals**

Action

The Commission will hear brief presentations on recommendations on supporting counties as they transition to the BHSA and utilizing their Innovation dollars to plan for behavioral health reform. The Commission will also hear from counties on their Innovation proposals and will learn more about how these proposals align with the BHSA and county level planning for the BHSA. The following Innovation proposals will be considered for approval:

1. Ventura: Early Psychosis Learning Health Care Network Collaborative
2. Fresno: Extension of California Reducing Disparities Project (CRDP)
3. Mendocino: Native American Crisis Line Collaboration
4. Fresno and Shasta: Psychiatric Advanced Directives (PADs)

- Public Comment
- Vote

2:30 p.m. **8. May Revise Budget Update**

Information

The Commission will hear an update on the state budget and Governor's May Revise budget proposal; *presented by Norma Pate, Deputy Director, Administrative Services and Performance Management*

- Public Comment

3:00 p.m. **9. Strategic Plan**

Action

The Commission will hear an update on the 2024-2027 Strategic Plan implementation efforts being used to accomplish the Strategic Plan goals and objectives; presented by Norma Pate, Deputy Director, Administrative Services and Performance Management

- Public Comment
- Vote

4:00 p.m. **10. Adjournment**

Our Commitment to Transparency

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

Our Commitment to Those with Disabilities

Pursuant to the Americans 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.

Notes for Participation

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 fail, 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 Subcommittee 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, 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

May 23, 2024 Commission Meeting

April 25, 2024 Meeting Minutes

Summary:
The Mental Health Services Oversight and Accountability Commission will review the minutes from the April 25, 2024 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) March 25, 2024 Meeting Minutes; (2) April 25, 2024 Motions Summary

Handouts: None

Proposed Motion: That the Commission approves the April 25, 2024 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date April 25, 2024

Time 9:00 a.m.

Location MHSOAC
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*
Itai Danovitch, M.D.
David Gordon
Jay Robinson, Psy.D.
Alfred Rowlett

*Participated remotely

Members Absent:

Assembly Member Carrillo
Senator Dave Cortese
Gladys Mitchell

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Maureen Reilly, Interim Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Lauren Quintero, Chief, Administrative Services
Jigna Shah, Chief, Innovation and Program Operations
Kallie Clark, Ph.D., Research Supervisor
Kimberly Watkins, Personnel Officer
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

[Note: Agenda Items 6, 7, and 8 were taken out of order. These minutes reflect these Agenda Items as listed on the Agenda, meaning they remain in chronological order.]

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:03 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.

Maureen Reilly, Interim Chief Counsel, called the roll and confirmed the presence of a quorum.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

John Boyd Acknowledgment

Former Commissioner John Boyd was unable to be in attendance, but, on behalf of the Commission, Chair Madrigal-Weiss presented a resolution in absentia in appreciation and gratitude for Dr. Boyd's contributions and years of service with the Commission that will be delivered to him offline.

Full-Service Partnership (FSP) Site Visit

Chair Madrigal-Weiss stated FSPs are a core strategy for supporting Californians with serious mental illness (SMI), including approximately 12,000 children and 8,000 transitional age youth. To better understand the experiences of youth FSP partners and their families, the Commission conducted a site visit to Butte County's Youth Intensive Program (YIP) FSP yesterday. The YIP serves eligible FSP clients who require assistance in managing their mental health conditions. The resources offered by the YIP are centered around the behavioral health needs of youth and families and are cross integrated with local entities to enable easy access to care and allow gradual transitions to lower tiers of care.

Chair Madrigal-Weiss stated youth who have utilized services from the YIP have experienced fewer hospitalizations, home displacements, and juvenile justice system involvements. She invited Commissioners who attended yesterday's site visit to share about the experience.

Commissioner Brown stated Commissioners and staff were given a tour of the facilities, which were centralized on a behavioral/public health campus with adjacent buildings with services that are complementary to the work being done. He stated, like most counties, Butte County is struggling with a large staff-to-client ratio. However, they are adapting and making good use of available resources. He stated one of the things that

touched him was that the one Peer Support Specialist on staff was there with a consumer's guardian who would bring the youth into class but was also struggling with the youth's developmental and mental health issues. The guardian stated the Peer Support Specialist was essentially a family support specialist who made the journey much easier for him and the rest of the family. This is a testament to the fact that they are adapting and have taken an all-hands-on-deck approach. Unfortunately, many counties in California will need to take this approach, due to the lack of staff, resources, and funding. Butte County is doing a good job utilizing the resources available to them.

New Staff

Chair Madrigal-Weiss asked staff to share recent staff changes since the last Commission meeting:

- Jigna Shah, Chief, Innovation and Program Operations, introduced Claire Sallee, the new Health Program Specialist in the Program Operations Unit.
- Kallie Clark, Ph.D., Research Supervisor, introduced Boyang Fan, Ph.D., the new Research Scientist in the Research and Evaluation Unit.
- Kimberly Watkins, H.R. Manager, introduced Pamela Nelson, the new Executive Assistant in the Administration Unit.
- On behalf of the Commission, Chair Madrigal-Weiss welcomed Claire Sallee, Boyang Fan, and Pamela Nelson to the Commission.

Commission Meetings

- The February 2024 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 Commission's Client and Family Leadership Committee and Cultural and Linguistic Competency Committee will be reconvening starting in May. Serving as the Commission's longest standing Committees, the CFLC and CCLC have been fundamental in ensuring community voices and perspectives are reflected in the Commission's work. Under the leadership of Commissioner Chambers and Commission Vice Chair Alvarez, Committees will now have an enhanced role of supporting implementation of the Commission's strategic goals and objectives. To make the most of this transition, past CLCC and CFLC members have been invited to return and participate in four meetings between now and June 30, 2025.
- The first meeting will take place virtually on May 8th. This will be a joint meeting involving both CLCC and CFLC members to discuss Committee goals and meeting dates. CLCC and CFLC meetings will be scheduled separately for the remainder of the term.

Chair Madrigal-Weiss invited Commissioner Chambers and Vice Chair Alvarez to say a few words about the new Committee plans.

Commissioner Chambers encouraged Committee members to get involved and engaged as the mental health system transforms and as the Commission's strategic plan is implemented. It is important to include the peer voice in diverse communities.

Vice Chair Alvarez stated appreciation for the commitment and continued expertise from Committee members. She acknowledged the opportunity with the new strategic plan and the fact that these Committees are a formal structure that receives valuable input and guidance from diverse community and family perspectives that will strengthen the implementation of the strategic plan for the next few years. She encouraged current Committee members to continue this commitment and to reach out with questions. She thanked Committee members in advance for lending their continued time and expertise.

Fentanyl Crisis

California is currently grappling with a fentanyl crisis among its youth. In response, the Legislature has proposed various preventative measures, including permitting students to carry Narcan on campus. Chair Madrigal-Weiss instructed staff to monitor these measures and report back on their progress in the Legislature. She stated she looks forward to hearing about the state's efforts to address this crisis.

2024 Master Plan for Aging Day of Action

In 2023, the Commission worked with the California Department of Aging to identify two programs, Age Wise and PEARLS, to receive Mental Health Wellness Act funding to expand those programs. The Department of Aging has extended an invitation for Commissioners to attend the 2024 Master Plan for Aging Day of Action in Sacramento on October 8th. More information will be available closer to the event date.

MHSOAC Podcast

The Commission will soon launch a podcast which will highlight the Commission's various projects, bringing light to mental health research animated by testimonials from experts, internal and external partners, and consumers with lived experience. This effort ties directly to the Commission's strategic plan goals of elevating the perspective of diverse communities, disseminating learnings from innovation and best practice, and growing public interest and awareness in the work of the Commission, other state agencies, and community-based organizations. The plan is for Commissioners to be involved in the project by sharing their thoughts and perspectives of the behavioral health system, and for the podcast to elevate community voice on behavioral health needs.

3: General Public Comment

There was no public comment.

4: February 22, 2024, Meeting Minutes

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the February 22, 2024, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

There were no questions from Commissioners and no public comment.

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

- *The Commission approves the February 22, 2024, Meeting Minutes, as presented.*

Motion passed 9 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Brown, Danovitch, and Gordon.

5: Conflict of Interest Code

Chair Madrigal-Weiss stated the Commission will consider approving amendments to the MHSOAC Conflict of Interest Code, which will be filed with the Fair Political Practices Commission. She asked staff to present this agenda item.

Lauren Quintero, Chief of Administrative Services, provided an overview, with a slide presentation, of the background, draft amendments, and next steps to the Commission's Conflict of Interest Code.

There were no questions from Commissioners and no public comment.

Action: Chair Madrigal-Weiss asked for a motion to adopt the amendments to the Conflict of Interest Code. Commissioner Brown made a motion, seconded by Commissioner Danovitch, that:

- *The Commission adopts the amendments to the Conflict of Interest Code and authorizes the Executive Director to initiate the Rule Making Process prior to filing the Code with the Fair Political Practices Commission.*

Motion passed 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

[Note: Agenda Items 6, 7, and 8 were taken out of order and were heard after Agenda Item 9.]

6: Transformational Change in Behavioral Health: Prevention and Early Intervention

Chair Madrigal-Weiss stated the Commission will be focusing on the passing of Proposition 1 and transformational change in behavioral health. The Commission has invited leadership from the California Health and Human Services Agency (CalHHS) to outline their strategy to implement Proposition 1. The goals for this presentation are to understand the state's plans to implement Proposition 1, identify the role of the Commission, and provide the public with an opportunity to hear from the Administration on its plans. She invited the representative from CalHHS to present this agenda item.

What Can be Done Now

Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS, stated much can be done now to act with urgency for the most ill, unsheltered, and vulnerable populations through the existing MHSA. She provided an overview, with a slide presentation, of the Administration's commitment to Californians; county tools to serve high-risk/high-need populations, such as Behavioral Health Bridge Housing, Medi-Cal Mobile Crisis Services, and the Behavioral Health Continuum Infrastructure Program (BHCIP); FSP; Community Assistance, Recovery, and Empowerment (CARE) Act; LPS conservatorship reform; and opioid response.

Ms. Welch stated much planning and discussion will be required prior to the July 1, 2026, implementation of the first county Three-Year Plan. County partners and their networks of care are already implementing major changes, due to the fact that California is still in the midst of a behavioral health crisis.

Ms. Welch stated 304 mobile crisis teams have been created in California through the BHCIP. The goal is for all 58 counties to have Medi-Cal Mobile Crisis Plans approved by June 30, 2024. 31 counties' Plans have been approved to date.

Ms. Welch stated, under the MHSA, FSPs focus on individuals with SMI and children and youth with serious emotional disturbance (SED). This will be expanded to include individuals with substance use disorder (SUD) as part of the new Behavioral Health Services Act (BHSA). Counties are now using the FSP model to pay or provide housing supports for individuals in FSPs. As California transitions to the BHSA, this will be an important part locally to ensure that FSPs are operating and serving populations with high needs.

Ms. Welch stated eight counties that represent most of the state's population are implementing the CARE Act. Learnings from Cohort 1 are that one of the keys to success has been early and frequent collaboration between court partners, housing and social services providers, and behavioral health providers; and that this intensive engagement and the ability to do a true Maintaining Fidelity to Assertive Community Treatment (ACT) Model FSP with this population has been effective, especially engaging someone early. She shared photos from recent site visits.

Ms. Welch stated the Department of Health Care Services (DHCS) has issued a Guidance Notice around LPS Reform as passed under Senate Bill (SB) 43, listing allowable sites where individuals under the expanded definition of "grave disability" can be taken. An FAQ document is currently being developed to add clarity.

Ms. Welch stated, because the MHSA was expanded into the BHSA to include individuals with SUDs, many investments to address the opioid crisis can be leveraged and hopefully built upon, most notably reducing barriers to care, ensuring access to treatment, including the California Medication-Assisted Treatment Expansion Project, and increasing the ability to support service providers.

Proposition 1 – Build for Transformation: Bond Overview

Ms. Welch continued her slide presentation and discussed the Behavioral Health Infrastructure Bond funding – treatment sites, supporting housing, supporting housing for veterans, BHCIP awards to date, and BHCIP Rounds 1 through 5.

Ms. Welch stated the non-BHSA portion of the bond was AB 531, which provided $6.3 billion of bond funding with up to $4.4 billion for competitive grants for counties, cities, tribal entities, non-profit, and private sector partners to build out behavioral health treatment settings emphasizing residential settings. Of the $4.4 billion available for treatment sites, $1.5 billion, with a $30 million set-aside for tribes, will be awarded through competitive grants only to counties, cities, and tribal entities. These competitive grants will be modeled on the BHCIP Program. Additional requirements, due to the provision of receiving bond funding, will be outlined in the Request for Applications (RFA).

Ms. Welch stated the $2.2 billion BHCIP Program funding was awarded in five rounds, although only Rounds 1 through 3 – crisis mobile unit grants, county and tribal planning grants, and launch-ready grants – are brick-and-mortar facilities. She reviewed the goals and outcomes of BHCIP Rounds 1 through 5.

Ms. Welch stated the Behavioral Health Infrastructure Bond funding for supportive housing is modeled after the California Department of Housing and Community Development's (HCD) existing HomeKey Program. The thing that will be different is that it must target individuals who are not just at risk for homelessness but have behavioral health challenges. Entities eligible to apply for this funding are cities, counties, and regional and local public entities. She noted that she has a slide deck of HomeKey Program examples that she can make available to staff.

Ms. Welch stated the Behavioral Health Infrastructure Bond funding for supportive housing for veterans has over $1 billion of housing investments earmarked for veterans who are experiencing homelessness, are at risk of homelessness, or have a mental health issue or SUD. CalVet and HCD will coordinate to determine the methodology of how these funds are distributed. One component is to ensure that the administrator of supportive housing has a coordinated service plan. The purpose of these plans is to strategize and leverage the kinds of services that are available through the Veteran's Administration and the kinds of services still needed. Like the BHCIP, this program builds off existing programs that have shown success, such as the Veterans Housing and Homeless Prevention Program.

Proposition 1 – Plan and Act for Transformation: BHSA Overview

Ms. Welch continued her slide presentation and discussed legislative findings, funding allocations and flexibility of the BHSA, engagement with local government, community engagement, and initial behavioral health transformation milestones. She stated, although the BHSA will take a lot of planning, that does not mean that actions cannot be taken now to prepare for those changes to take place. She stated the landscape of how the mental health system is funded has dramatically changed in the last 20 years. Medi-Cal can now provide more services to meet the need, such as the ACT program and peer services as part of the Medicaid program. Strides have been made in achieving more parity between commercial plans and the Medicaid program. One of the commitments made as part of behavioral health transformation was to assess where there were gaps between commercial coverage and Medi-Cal. One of the gaps identified was peer services.

Ms. Welch summarized the changes of the BHSA. She stated the BHSA updates allocations for local services, includes new state responsibilities with directed funding, broadens the target population to include individuals with SUD, focuses on the most vulnerable and at-risk including children and youth, clearly advances community-defined practices as a key strategy of reducing health disparities, increases community representation, revises county processes, and improves transparency and accountability.

Ms. Welch reviewed the BHSA local services funding categories and the new state responsibilities funding categories. She noted that part of the new state responsibilities includes $20 million annually for the MHSOAC, now named the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), to administer the BHSA Innovation Partnership Fund, which will be used for improving BHSA programs for underserved, low-income populations and communities impacted by behavioral health disparities.

Ms. Welch stated BHSA funding is flexible. Counties will have the flexibility to move up to 7 percent from one funding category into another, for a maximum of 14 percent more added into any one category, to allow counties to address their different local needs and priorities, based on data and community input. Changes are subject to DHCS approval and can only be made during the three-year plan cycle. The next cycle is Fiscal Year (FY) 2026-29. Innovation is permitted in all categories.

Ms. Welch stated the Commission will be part of the future CalHHS Revenue Stability Work Group, which will look at strategies to manage the annual variations in the MHSA Fund so counties can do more long-range budget planning.

Ms. Welch stated the BHSA will include new reporting requirements. An additional 2 percent of local BHSA revenue may be used to improve planning, quality, outcomes, data reporting, and subcontractor oversight for all county behavioral health funding, on top of the existing 5 percent county planning allotment. It is important for counties to use some of these resources to support training and technical assistance to ensure that interested parties have enough information and data to meaningfully participate in the development of three-year County Integrated Plans for Behavioral Health Services and Outcomes and annual updates.

Ms. Welch reviewed the timeline for the DHCS initial behavioral health transformation milestones. Community engagement, including monthly public listening sessions, will begin in the spring of 2024 and RFAs for bond funding leveraging the BHCIP and HomeKey Models will begin in the summer of 2024. Policy and guidance will be released in phases beginning with policy and guidance for County Integrated Plans in early 2025, and new County Integrated Plans, fiscal transparency, and data reporting requirements will roll out in July of 2026 for the next three-year cycle.

Opportunities for Change in the BHSA

Ms. Welch continued her slide presentation and discussed priority populations for the BHSA, health equity in the BHSA, the inclusion of SUD services, behavioral health housing interventions, FSP programs, Behavioral Health Services and Supports (BHSS), BHSS early intervention details, priorities, program focus, new state responsibilities, and innovation.

Ms. Welch reviewed the criteria for priority populations that will be served with BHSA funding. These populations will be aligned with the Medicaid Program. She stated this is important because these populations are already eligible for Medicaid so it made sense to prioritize these populations in the BHSA.

Ms. Welch stated the BHSA has exciting elements to advance health equity, including language about reducing silos, particularly in the early intervention component; advancing community-defined practices in the FSP funding category as a key strategy of reducing health disparities and increasing community representation; and stratifying data and strategies for reducing health disparities in planning, services, and outcomes, including additional representation of diverse perspectives on state and local oversight bodies.

Ms. Welch stated programs and services may include SUD treatment services. One of the ways this will be managed is that counties must use the data to appropriately allocate funding between mental health and substance use treatment services as well as identify strategies to address disparities between the level of service they are providing for mental health and SUD. This is clearly articulated in the section around the County Integrated Plan for Behavioral Health Services and Outcomes requirements.

Ms. Welch stated the target populations for the Behavioral Health Housing Interventions funding category includes children and families, youth, young adults, and older adults living with SMI, SED, and/or SUD who are experiencing or are at risk of homelessness. She stated she hears about many individuals living in unstable housing. She stated it is important to know that CalHHS wants individuals to feel stable in their housing. The Behavioral Health Housing Interventions funding category includes rental subsidies, operating subsidies, shared and family housing, capital, and the non-federal share for the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) waiver for six months of transitional rent. Because the future is uncertain, flexibilities are built into the requirements.

Ms. Welch stated the FSP Programs funding category includes mental health, supportive services, and SUD treatment services including Medication-Assisted Treatment (MAT) and Community-Defined Evidence Practices (CDEPs). She stated ACT/Forensic ACT, supported employment, and high-fidelity wraparound are required. Small county exemptions are subject to DHCS approval. These treatments and supports are part of the BH-CONNECT package as new services waiting approval from the federal Centers for Medicare and Medicaid Services (CMS) to receive federal financial participation (FFP) so they will be part of the optional array of Medi-Cal services that counties can provide.

Ms. Welch stated levels of care are being established based on criteria intended to support flow in and out of systems. The Commission has been identified as one of the CalHHS partners in working on developing these FSP levels of care. Outpatient behavioral health services are also supported in the FSP funding category, either clinic or field based, if they are necessary for ongoing evaluation and stabilization of an enrolled individual. The FSP funding category also includes ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services, including services to support maintaining housing. She noted that high-needs, high-risk, highly vulnerable populations may need ongoing engagement services to stay enrolled in their treatment plan.

Ms. Welch stated the Behavioral Health Services and Supports (BHSS) funding category includes all the other parts of the original MHSA: early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects. She noted that innovation is elevated in all areas of the BHSA. A majority of these resources must be used for early intervention services to assist in the early signs of mental illness or substance misuse. Also, a majority of that majority amount must be for individuals 25 years and younger.

Ms. Welch stated CalHHS worked hard on the BHSS early intervention section. She stated Section 5840 is similar to the original section. It emphasizes reducing negative outcomes associated with untreated mental illness, reducing disparities, and expanding and establishing a biennial list of CDEPs and evidence-based practices that may include practices identified pursuant to the Children and Youth Behavioral Health Initiative (CYBHI). She stated the DHCS, in consultation with the BHSOAC, counties, and interested parties, shall establish this list. She noted that counties may act jointly to meet the requirements of this section.

Ms. Welch stated the Commission plays an important role in the early intervention section of the BHSS funding category. She reviewed the priorities for this section:

- Strategies targeting the mental health needs of eligible children and youth who are 0 to 5 years of age, including, but not limited to, infant and early childhood mental health consultation.
- Early psychosis and mood disorder detection and intervention and mood disorder programming that occurs across the lifespan. Outreach and engagement strategies target early childhood 0 to 5 years of age, out-of-school youth, and secondary school youth. Partnerships with community-based organizations and college mental health and SUD programs may be utilized to implement the strategies.
- Strategies to advance equity and reduce disparities, including culturally-competent and linguistically-appropriate interventions.
- Strategies targeting the mental health and SUD needs of older adults.
- Programs that include CDEPs that have been successful in reducing the duration of untreated SMI and SUDs.
- Strategies to address the needs of individuals at high risk of crisis.

- Other programs that are proven effective in preventing mental illness and SUDs from becoming severe and disabling.

Ms. Welch stated the program focus for the BHSS Early Intervention Program is outreach, access and linkage, and mental health and SUD treatment services. She reviewed these focus areas in detail:

- Outreach to families, employers, primary care health care providers, behavioral health urgent care, hospitals, education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and SUDs.
- Access and linkage to medically necessary care provided by county behavioral health programs as early in the onset of these conditions as practicable.
- Mental health treatment services may include services to address first episode psychosis.
- Mental health and SUD services shall include services that are demonstrated to be effective at meeting the cultural and linguistic needs of diverse communities.
- Mental health and SUD services may include services that prevent, respond, or treat a behavioral health crisis.
- Mental health and SUD services may be provided to children and youth experiencing or at high risk of trauma, child welfare, juvenile justice system involvement, and/or homelessness.

Ms. Welch stated Population-Based Prevention is a new state responsibility funding category, administered by the California Department of Public Health (CDPH) in consultation with the BHSOAC and the DHCS. 51 percent of this funding must serve individuals 25 years and younger by using school-based care and school partners to prevent and promote early access to treatment of care. Population-based prevention strategies are intended to reduce the prevalence of mental health and SUDs and to promote evidence-based programming or CDEPs that meet one or more of the following conditions:

- Target the entire population of the state, county, or a particular community to reduce the risk of individuals developing mental health challenges or SUD.
- Target specific populations at elevated risk for mental health challenges, substance misuse, or SUD.
- Reduce stigma associated with seeking help for mental health challenges and SUD.
- Target populations disproportionately impacted by systemic racism and discrimination.
- Seek to prevent suicide, self-harm, or overdose.

Ms. Welch stated population-based prevention programs may be implemented statewide or in community settings and shall not include the provision of early intervention, diagnostic, and treatment services for individuals. Early childhood programs for children 0 to 5 years of age shall be provided in a range of settings.

Ms. Welch stated Statewide Workforce is a new state responsibility funding category, administered through the Department of Health Care Access and Information (HCAI) in collaboration with CalHHS to implement a behavioral health workforce initiative to expand a culturally-competent and well-trained behavioral health workforce. She stated the CYBHI was the first time a substantial investment in the behavioral health workforce was achieved. Under this Administration, it was a challenge because, to expand the workforce, the ability to train individuals needed to be expanded – for example, more professors or more slots in schools. Now that this is a sustained funding source, reimagining how the workforce of tomorrow will be trained and building the capacity to do so can be realized.

Ms. Welch stated another piece of the BHSA is innovation. The mechanism to assess how innovation is being done at the local level is through the County Integrated Plan for Behavioral Health Services and Outcomes, which must demonstrate how the county will strategically invest in early intervention and advance behavioral health innovation. $20 million annually will be directed to the BHSA Innovation Partnership Fund, administered by the BHSOAC, to develop innovations with non-governmental partners.

Enhanced Accountability

Ms. Welch continued her slide presentation and discussed the County Integrated Plan for Behavioral Health Services and Outcomes. She reviewed what has not changed from the old three-year plan requirements: a local robust community engagement process, plans go through local behavioral health advisory boards, and plans are signed off by the board of supervisors. She reviewed the changes in the new County Integrated Plan: it brings all sources of funding to share the whole picture of how a county is funding its plan responsibilities; includes a budget of planned expenditures, reserves, and adjustments; includes workforce strategies; and must be in alignment with statewide and local goals and outcomes measures.

Ms. Welch stated County Integrated Plans must be developed with consideration of the population needs assessments of each Medi-Cal Managed Care Plan and in collaboration with local health jurisdictions on community health improvement plans, and must be informed by local community input, including additional voices on local behavioral health advisory boards. She stated performance outcomes will be developed by the DHCS in consultation with counties and interested parties.

Ms. Welch stated the County Behavioral Health Outcomes, Accountability, and Transparency Report is the impact plan. Counties will be required to report annually on expenditures of all local, state, and federal behavioral health funding, unspent dollars, service utilization data and outcomes with a health equity lens, workforce metrics, and other information. One thing substantially different is that the DHCS is authorized to impose corrective action plans on counties that fail to meet certain requirements.

Ms. Welch stated the plans and reports shall include data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts. Other data and information may include the number of people who are eligible adults and older adults; incarcerated; experiencing homelessness, inclusive of the availability of housing; and eligible children and youth.

These metrics shall be used to identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs.

Ms. Welch stated the State Auditor shall issue a comprehensive report on the progress and effectiveness of the implementation of the BHSA by December 31, 2029, and every three years thereafter until 2035. The report will assess the success of the massive changes being implemented.

Ms. Welch stated the DHCS will consult with the BHSOAC on developing a biennial list of early intervention evidence-based practices, building FSP levels of care, developing statewide outcome metrics, and determining statewide behavioral health goals and outcome measures. The CDPH will consult with the BHSOAC and DHCS on population-based mental health and SUD prevention programs.

Ms. Welch stated the BHSOAC will consult with CalHHS and the DHCS to determine allowable uses of funds for the BHSA Innovation Partnership Fund, and with CalHHS to discuss funding allocations created by the Investment in Mental Health Wellness Act. The Commission will also consult with the CDPH for population-based prevention innovations, and the HCAI for workforce innovations.

Ms. Welch stated the BHSOAC will collaborate with CalHHS to promote transformational change through research, evaluation, and tracking outcomes, and the DHCS and the California Behavioral Health Planning Council (CBHPC) to write a report with recommendations for improving/standardizing BHSA promising practices. She noted that members of the BHSOAC are members of the CBHPC.

Ms. Welch concluded her presentation by directing everyone to the DHCS website for more information on California's behavioral health transformation.

Commissioner Comments & Questions

Commissioner Danovitch stated real-time data was used for patients, the symptoms they had, their response to symptoms, and the severity when transforming the existing health care system to respond to COVID-19 to drive awareness of performance to make the system work. He referred to the County Behavioral Health Outcomes, Accountability, and Transparency Report, and asked what the DHCS can do to help facilitate getting patient-level outcomes data that can be used to drive awareness of disparities, who is performing well, the regions that are struggling, and how to hold all spending and services accountable to drive change.

Ms. Welch stated the DHCS can better answer that question. She stated part of the problem is antiquated data systems. She stated the hope to have the capacity and resources to invest in reimagining those systems. Real-time data on patient outcomes is one of the areas that CalHHS wants to work with the Commission on.

Commissioner Danovich stated measures are needed to incentivize change in order to facilitate everything else. These measures already exist in repositories but the data is siloed. This must be prioritized and overcome.

Commissioner Danovich stated the service delivery system is separated by innumerable barriers to delivering on objectives. He asked how the Commission and the DHCS can help support CalHHS in developing strategies to address those barriers from the outset.

Ms. Welch stated one of the positive things she has heard about this initiative is not just the inclusion of SUD, but the fact that SUD being included in the BHSA can catapult efforts around integration. She stated the SUD service delivery system is a priority.

Commissioner Robinson stated one of his biggest concerns is around workforce development. There is already a shortage of health care providers, and this initiative is hinged on having workers to deliver services. The budget for workforce development seems meager relative to the need. He asked how this will be addressed.

Ms. Welch stated CalHHS is planning to host an educational forum on the two workforce initiatives underway. Results are beginning to be seen. She noted it cannot just be about more people, but it must be about different types of people doing different things and working more efficiently. CalHHS has recruited an individual to lead the workforce efforts who will be assessing the current workforce to learn what everyone is doing now and reimagining who can work in what space. She stated CalHHS has just short of 1,000 individuals registered to become Certified Behavioral Wellness Coaches. She asked the Commission to think creatively about bringing in other partners to help create this workforce faster. She suggested providing an update at a follow-up presentation.

Commissioner Chambers referred to the Outpatient Care section on page 4 of the Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts document, which was included in the meeting materials, and stated she appreciated the behavioral health-focused investigations into the parity of commercial health plans; however, the peer workforce is not included in that workforce. She stated it is troublesome to highlight how great peers are and how they are doing great work, while peers remain unable to practice outside of opt-in behavioral health.

Commissioner Chambers referred to the Crisis Care section on page 4 of the Policy Brief and highlighted the success of the CalHOPE Program and stated it is a low-barrier access to care. She stated CalHOPE has been threatened to be cut multiple times. This has created instability for providers and Californians who need low-barrier access into care.

Ms. Welch stated positive conversations have taken place about the value of looking at using different types of individuals in the workplace, especially trying to do different types of services.

Commissioner Chambers referred to the Inpatient Care section on page 5 of the Policy Brief and stated a recent report showed that many individuals are stuck in inpatient care facilities. She stated, while focusing on other systems of care, there is a need to ensure that there are places for individuals to go when they are released from the hospital. Community-based peer-run organizations are available to help individuals function in society. She stated the need to commit to community-based services in transitioning individuals out of the hospital.

Commissioner Chambers stated she was excited to learn about the emphasis on health plans to focus on the justice involved homeless population, yet some of those individuals will not be eligible for Peer Support Specialist certification. She stated the need to work in these systems to get Peer Support Specialist certification through

Medi-Cal. She highlighted consumers and family members as an integral part of getting individuals into treatment, ensuring therapeutic alliances, adhering to treatment planning, and supporting individuals when they get out of facilities.

Ms. Welch stated the value of peers is being heard.

Commissioner Brown stated concerns about part of the crisis care element of the plan and what is happening now, particularly with respect to the guidelines and regulations that have been issued that provide that Medi-Cal funding is not available for crisis response teams that include a law enforcement responder. He stated 37 counties in California have some form of law enforcement/behavioral health co-response. The guidelines and regulations seem to be an interpretation of the federal recommendation from the CMS in that they are not requirements. Other states do not have this restriction for teams that include a law enforcement co-responder.

Commissioner Brown stated his county has had great success with its crisis program. It is popular among a variety of different sectors within the community including families of individuals who suffer from SMI. There is a push to go to teams that do not include law enforcement; however, it has been seen recently that Los Angeles is in the process of shutting down their program, where they had paramedics responding with mental health professionals with poor results. He asked that this issue be shared with the Governor and the DHCS as something that needs to be rectified.

Commissioner Rowlett spoke about population health management and payment reform. He stated a necessary transition to value-based care has begun. As this is done, managed care plans and community-based organizations are intersecting more. As it pertains to the mild to moderate population, there are additional strategies that the state can mandate around transparency and risk-sharing that would enhance the beneficiary's experience with the goal of the beneficiary to have greater use of their benefit. Using benefits better would reduce the inappropriate use of different types of health care. This requires greater transparency and more collaboration, which points to risk-sharing.

Commissioner Rowlett stated the DHCS indicates that a variety of different types of funding and opportunities to access it have been brought into California to improve the behavioral health problems in the state. He stated he does not always hear that from counties. It might be helpful to invite Michelle Cabrera, the Executive Director of the County Behavioral Health Directors Association (CBHDA), to present at a future meeting on her perspective on this issue.

Commissioner Rowlett stated outpatient funding got his attention. The presenter talked about utilizing funds from the FSP funding category for those individuals who are being served in the county-funded outpatient system. He asked about concerns that the funding for their services might be improved because they could utilize some of the dollars from the FSP category.

Ms. Welch stated the statute says that FSPs will have levels. A clinically-enriched field-capable-based services outpatient program is a potential level of an FSP. The top level of an FSP is a Fidelity Act Model Program that serves the most intensive low-caseload individuals with the most serious and persistent mental illnesses. Individuals do not

always need this level of care. She stated this is why CalHHS wants to work with the Commission and the DHCS, which is intending to have a work group process on what those levels look like.

Ms. Welch stated there are individuals who will be enrolled in an FSP and getting services in outpatient settings. She noted that these individuals must be enrolled in an FSP. The law states that, if someone is enrolled in an FSP, they can receive outpatient services, either clinic- or field-based, if it is necessary to keep them stabilized. Many counties are already doing this. She stated the need for clarity on how some individuals who should be being served successfully with the supports of Enhanced Care Management (ECM) and Community Services and Supports (CSS) can be better served. It is important to partner together and have detailed conversations as part of the planning process about how to make this work to serve individuals who are the intended target population.

Ms. Welch stated the initiative is about supporting all systems to fulfill their target population responsibilities. She noted that none of this will be easy and done overnight. It is important to consider how to be successful in all systems.

Commissioner Rowlett spoke about accessibility of data to inform services during implementation of this initiative. He stated the idea was to use data to objectively inform the service provision over the course of years. The hope is to access data in a timely manner to information service delivery and make critical adjustments.

Ms. Welch stated she was unable to comment on this metrics question but will take it back to the team. She noted that this issue is not new. The discussion on how to have real-time data to better serve clients is ongoing.

Commissioner Gordon stated appreciation for the work of the teams at CalHHS, DHCS, and HCAI to make a difference. He stated data is important but he noted that the state typically does not handle data well. It is worth investing more resources to get an operational system working better for this effort. The same thing is true with workforce. He stated there may be an underinvestment in this area because workforce is at the heart of the matter.

Commissioner Gordon stated the biggest barrier he has seen is the lack of access to services, particularly in underserved communities and in children 0 to 8 years of age, where real prevention can occur. This aspect of the initiative should be boldly prioritized. Schools are in a position to help with this issue. It takes building relationships to help individuals trust the system and come forward for treatment. Many times, services are remote but there are schools in every community with trusting relationships built around each school. This would be a good start toward bringing better access at a much earlier age, which will make a difference five to ten years from now.

Commissioner Carnevale stated data is vital. Issues cannot be impacted without measures in place. Much has been done through this initiative but the vastness of the depth of need is still unknown. The work of the Commission around innovation and closing the gap between the public and private sectors is exactly the kind of problem the Commission is trying to facilitate solving. There is capacity in Silicon Valley to solve these problems, but there is not a mechanism for government to access it. The

Commission is trying to create something akin to an open innovation platform that will help to define these kinds of problems and find individuals who can solve them more rapidly the smart way. He stated the Commission can help solve issues that, although everyone wants them solved, never seem to be addressed.

Commissioner Bunch stated she supervises a large clinic for Los Angeles County. While all clients who meet the criteria are referred to FSP Programs, not all clients meet the criteria based on the current structure. Individuals who do not meet the criteria are considered outpatient. She asked how the FSP levels will work in her example and if the requirements for FSP will be changed.

Ms. Welch stated FSP is not a concept in the MHSA but it is in the CSS Regulations. FSPs are operated differently county to county. She suggested posing this question to the DHCS workgroup to consider. There is an opportunity to design the FSP levels of care that make sense and are in the clinical best interest of individuals in care. She stated CalHHS is interested in Commissioners who have the expertise and are working in the field to help figure these levels out. She stated there are probably individuals being served by the county behavioral health system who potentially could be served by the Medi-Cal Managed Care System. CalHHS wants to have this conversation with the Commission.

Chair Madrigal-Weiss referred to the Community Engagement slide and stated appreciation that county behavioral health advisory boards must reflect the diversity and demographics of the county. She referred to the County Behavioral Health Outcomes, Accountability, and Transparency Report slide and stated counties will be required to report annually on unspent dollars, service utilization, and data and outcomes with a health equity lens, workforce metrics, and other information. She suggested adding disparity reduction to this list.

Vice Chair Alvarez stated the need to identify disaggregated data to better understand how the hard-to-reach populations are being reached and to find ways to ensure that can be improved.

Ms. Welch stated an important part of the initiative is requiring stratified data and strategies for reducing health disparities.

Vice Chair Alvarez stated the presenter mentioned the alignment to Medi-Cal definitions for specific populations. This makes sense and speaks to the Department’s holistic perspective on behavioral health. At the same time, those definitions often close the door to services and supports for the broader Medi-Cal population that has yet to reach a crisis, but they still have challenges in navigating the necessary community mental health supports and services they need.

Ms. Welch asked for further details.

Vice Chair Alvarez stated the presentation referenced the defined populations for Medi-Cal reimbursement. She stated this closes the door to services and supports for populations that do not meet those definitions, such as young people who may not be in crisis or may not be in the system. Many times, families that want to prevent crisis do not know where to get those services, are having challenges, want to reach community services and supports, and are unable to do so. Part of what has been challenging with

the efforts to include community-based interventions in Medi-Cal is that many times community organizations do not have the capacity to bill Medi-Cal or they are not familiar with those systems.

Vice Chair Alvarez stated Medi-Cal is not the end-all be-all. She stated the need not to close the door on community providers who are providing services and supports to a broader population of people who still need community mental health interventions. It is important to consider what that looks like and how those funding streams are sustained. She stated the need for clarity on how community mental health interventions will continue to be sustained.

Ms. Welch stated a person does not need to be on Medi-Cal to benefit from BHSA dollars. The provision is, if there is a service that can be reimbursed under Medi-Cal, that reimbursement is to be sought. She stated this might be a longer conversation with individuals with expertise in this area. She stated she shares Vice Chair Alvarez's concern. CalHHS recognizes that there is work to do to encourage, incentivize, and support more providers to become certified Medi-Cal providers. She asked the Commission to help consider how to support individuals to be a part of that system, learn about barriers, and consider how to create more administrative efficiencies and incentives to be a part of that system.

Vice Chair Alvarez asked for additional thoughts on the continued conversation on assessing the process. She stated this is a huge undertaking and is brand new. Where there are opportunities for further engagement with the Commission to assess how things are going moving forward, particularly regarding prevention and early intervention, it is important to discuss the impacts of the big shift in responsibility to the state with a focus on children, young people, and moving upstream.

Vice Chair Alvarez stated the need for open dialogue and identifying opportunities to connect with county and community leaders, the state, and this Commission to better understand the impact moving forward. Although the future is uncertain, everyone wants to ensure that crisis and SMI can be prevented. Finding opportunities for assessment is particularly important.

Ms. Welch stated CalHHS is trying to figure out what that assessment process is. The Commission is a part of that conversation. She asked for patience in terms of getting started in that process. She stated she can explore opportunities with Commission staff offline.

Commissioner Chambers stated there is a personal financial impact to serve on boards and Commissions, even when there is reimbursement from the state. She stated concern about setting people of color up, especially young people of color, to serve on boards without additional support.

Chair Madrigal-Weiss asked Commissioners about priorities to follow-up on at future Commission meetings. Commissioners suggested hearing updates and presentations on workforce, peers in the workforce, FSPs, SUD integration, reaching the hardest to reach, communities of color, prevention, housing, justice involvement, crisis response, early intervention, data, the county perspective, managed-care plans, and the logistical

impacts of the expansion of the size of the Commission – budget, facility, adequacy, support staff, reporting requirements, meeting frequency, locations, etc.

Chair Madrigal-Weiss asked Ms. Welch to help the Commission invite the right officials to present on these topics at a future meeting.

Public Comment

Richard Gallo, Medi-Cal Peer Support Specialist, speaking as an individual, stated concern about the housing component. There has been no mention of peer respite or a peer navigation center. Peers and peer workers were excluded from the planning process for Proposition 1. There are no definitions in Proposition 1 about peer workers or peer support. There are still counties that have not bought into Proposition 1 with community feedback. The MHSA failed because county behavioral health directors chose to not buy in to MHSA principles. The speaker stated the initiative should be penalized for not having a robust community planning process.

Ahmad Bahrami, Fresno County Department of Behavioral Health, stated it takes almost a full year for counties to make a three-year plan. He stated the need to provide as much information and details as possible and to provide ample time for counties to do thorough pre-planning and creating of their three-year plans.

Ahmad Bahrami stated the need to ensure that considerations are made for an equity lens. He stated the need for prevention to be considered through an equity and capacity lens. California has unique populations, cultures, and geographies. One of the effective things for prevention is being able to address current issues. It is important for the state to be responsive to issues and to address them immediately.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Ms. Welch for concisely presenting Proposition 1. She publicly thanked Ms. Welch and Michelle Baass, Director of the DHCS, for meeting with the REMHDCO and the California Reducing Disparities Project (CRDP) during the negotiation.

Stacie Hiramoto stated most CDEPs are both prevention and early intervention. She asked how CDEPs will be funded when those funding categories are split. Also, regarding early intervention, the current regulations require a recent diagnosis of mental illness or experiencing signs and symptoms. CDEPs do not usually require participants in their programs to reveal personal information.

Stacie Hiramoto stated appreciation that CDEPs were put in several places in Proposition 1; however, how well FSPs will utilize CDEPs is unclear. Also, REMHDCO agrees with the concerns brought up by Vice Chair Alvarez regarding Medi-Cal requirements. Although the MHSA did not require individuals to be Medi-Cal eligible, sometimes counties required individuals to be Medi-Cal certified in order to be funded.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, stated the census will now be collecting a new category of demographic data – Middle East and North Africa (MENA) region. Individuals of that descent have been categorized as white in the United States because, when individuals from Seria, Lebanon, etc., first immigrated to the United States, it was at a time when Southern Europeans were stigmatized. These populations

did not want to be categorized as Southern European Middle Eastern – at that time, they wanted to be considered white. Also, Assembly Bill (AB) 2763, the California MENA Inclusion Act, will soon be signed by the Governor. MENA is a new category in data collection and data analysis that will have relevance to what were prevention and early intervention requirements and training, which are now divided in this initiative.

Dr. Benhamida asked if post-traumatic stress disorder (PTSD) will be considered along with psychosis and how it will be handled. She noted that almost everyone who enters from a war or conflict zone is at risk for PTSD.

Michelle Smith, Senior Behavioral Health Manager, Orange County Behavioral Health Services, stated appreciation for the presentation on the vision of the state. As counties transition to this updated framework and the system redesign, it is important to receive updated information and guidance from the DHCS as soon as possible to help counties with planning so they can have meaningful discussions with their communities. Large counties need to begin their integrated three-year plan pre-planning now.

Michelle Smith asked for consideration on the accessibility of the plans. She said MHSA plans are now from 200 to 600 pages long and are difficult for the public to understand. She suggested providing information on how the MHSA was rolled out and how counties received information and guidance per component as a lesson learned that may have contributed to a segmented implementation of the MHSA. She stated it was almost like prevention and early intervention were outside of the system of care. It is important to ensure that counties take an integrated approach from the beginning in terms of that guidance. That would be helpful to counties and to communities so that, while engaging in the planning process, they look at the entire system of care and implement it in a cohesive way to meet the vision of the state and the vision and needs of the counties.

Commissioner Discussion

Chair Madrigal-Weiss thanked Ms. Welch for her excellent presentation and stated the Commission looks forward to working with her in the future.

7: Lunch

The Commission took a 30-minute lunch.

8: Transformational Change in Behavioral Health: Innovation

Chair Madrigal-Weiss stated the Commission will continue the discussion on transformational change in behavioral health. She asked staff to present this agenda item.

Executive Director Ewing provided an overview of the newly-adopted requirements on innovation, the vision behind those reforms, and the challenges and opportunity under the BHSA. He stated there are changes in the MHSA as it transitions to the BHSA related to innovation. He stated, under the current statutory structure, counties are required to set aside 5 percent of their MHSA funding for innovation. In order to spend that, counties must receive permission from the Commission. That 5 percent set-aside expires with the BHSA, but there is language in the law that requires counties to invest

in early intervention and to advance behavioral health innovation. The general expectation is that innovation will continue to happen.

Executive Director Ewing stated the first issue to consider is what Commission has learned about innovation funding over the years, and how to support these programs. Proposition 1 provides the opportunity to talk with county behavioral health partners about what innovation means moving forward. It eliminates the innovation funding requirement but calls for ongoing innovation.

Executive Director Ewing stated the second issue for the Commission to consider is that the local fiscal set-aside expires, but the Commission will still receive $20 million annually for innovation for the next five years with an opportunity for extension beyond those five years. In essence, the Commission will receive $100 million to support behavioral health innovation. This is consistent with the Chair's request for Commissioner Carnevale to lead a discussion of how best to use those dollars. He stated the Commission has an opportunity to prioritize the $100 million and leverage that to support innovation broadly defined.

Executive Director Ewing stated the third issue for the Commission to consider is that, as California shifts from the MHSA to the BHSA, there is a balance of MHSA innovation funds that are still available for expenditure. There may be up to $1 billion of MHSA innovation funds in the queue. The way the BHSA is structured allows counties to continue to use those funds for Commission-approved innovations even after the BHSA takes effect if they were approved by the Commission before that deadline.

Executive Director Ewing stated, working with the counties and the DHCS, it is estimated that there is approximately $250 million of new MHSA innovation dollars available and approximately $800 million of previously-approved innovation funds that have not yet been spent by counties. Some of those are in active projects that counties would need to stop pursuing if they wanted to repurpose those funds. Some of those funds are in Commission-approved innovation projects that have not yet begun. The Commission's rules have long recognized the need for counties to be able to revisit innovation decisions if a project was no longer a priority or was not working out as they had envisioned. The Commission did not want to create an incentive for counties to spend innovation funds in an approved plan if they decided that their initial plan was not working out. It is important that innovations "fail quickly" so funding can be redirected to innovations that work better for counties.

Executive Director Ewing stated, because the BHSA grandfathers in those decisions, counties will have two options. If counties choose not to use the funding for innovation, those dollars roll forward into the new funding categories under the BHSA in which innovation is eliminated. If counties choose to use the funding for innovation, the Commission can approve those innovations for any length of time, although the standard has been five years.

Commissioner Comments & Questions

Executive Director Ewing asked a series of questions to facilitate the discussion:

- How might the Commission support the ability of the counties to sustain innovations in their local programs?

- What strategies should the Commission consider to support the success of its direct funding for innovation beginning in 2026-27?
- Recognizing that counties continue to hold unspent MHSA innovation funding and the Commission has a queue of innovation funding requests for consideration, should the Commission encourage the use of innovation funds to support county transition from the MHSA to the BHSA?

Commissioners provided feedback as follows:

Commissioner Brown stated presumably a good portion of the approximately $800 million is money that has not been spent because counties do not have the bandwidth, staff, or ability to start and sustain these programs. He asked if the funding can be redistributed to other counties.

Executive Director Ewing stated, under the state's reversion rules, if a county does not shield these dollars by getting an innovation plan approved by the Commission, then they automatically revert and the state redistributes them to other counties.

Commissioner Brown asked at what point that funding stays in perpetuity.

Executive Director Ewing stated it does not stay in perpetuity. If the MHSA was not shifting to the BHSA, it would stay there until it hit a reversion deadline and the state would redistribute it or, for those counties that have been unable to make use of those dollars, they can repurpose them by coming to the Commission with a different proposal that is more viable, urgent, and doable for the county. The BHSA still provides the option to repurpose the funding, reversion could still be enforced, and any dollars left in the account that are not in a Commission-approved innovation plan will roll over and must be distributed into the new funding categories. The funding will revert within that county outside of innovation and into FSP, housing, or other BHSA funding category.

Commissioner Danovich stated he is supportive of guiding the counties to appropriately take advantage of the opportunity to spend innovation funds.

Commissioner Rowlett suggested that staff support counties to use their unspent innovation funding that would ultimately revert to prepare for the new reality. He asked if counties would be able to develop and sustain a different type of innovation plan effort prior to 2026. If not, redistributing the funding to one of the BHSA funding categories would be more beneficial to the counties. He stated the need for guidance on how counties can redistribute their unspent innovation funding.

Commissioner Chambers stated she has been speaking with small counties about the transition. One of the things that came up consistently was the concern about cutting programs, peer services, prevention, and early intervention. She stated concern that community-based services that bring individuals into higher levels of services will be cut. It is important to discuss innovations and data to help counties.

Executive Director Ewing stated it would be helpful to staff to understand the areas of the BHSA implementation that are concerning to Commissioners, such as cutting peer services. There are conversations that suggest that under the BHSA counties will not be allowed to fund peer services. There are other conversations that say counties are absolutely allowed to fund peer services but they are not required to. Hearing from

Commissioners not just as part of the innovation conversation but part of the broader conversation where the Commission asked Ms. Welch to help drill down into some of the issues, the Commission can help to clarify what the law allows, requires, and where there may be incentives including peer services, particularly recognizing the investment the state has made in getting the peer certification. He stated the need to determine if that momentum is lost.

Executive Director Ewing stated staff has had informal conversations with counties about their priorities on this transition, what causes the greatest anxiety, and how innovation dollars might help create clarity to address the unknowns or to put a game plan in place. This has not been done formally with the CBHDA.

Executive Director Ewing stated staff has had similar conversations with the Administration around a wish list to think about what should be on that list related to the transition. The issue of data systems has come up. The state has legacy data systems, some of which should no longer be legacy. This is an opportunity to revisit if some of the unproductive data-gathering and reporting requirements can be eliminated. Counties would benefit from updated data systems. The idea would be to dramatically reduce costs of these systems while fundamentally enhancing the utility for the state, counties, and communities.

Commissioner Bunch asked if the multi-county collaborative on psychiatric advance directives innovation plan would fit under the SUD, FSP, and housing funding categories.

Commissioner Chambers stated the multi-county collaborative on psychiatric advance directives innovation plan would fit in every funding category. The project is testing an app for real-time, treatment, and crisis intervention preferences, when individuals are interacting with law enforcement and hospitals. Peer supporters will be testing the model in these counties, which should be billable Medi-Cal services. The DHCS will provide guidance relative to that. This project will test a modality that can be used throughout the whole system of care to support individuals in crisis and treatment and strengthen therapeutic alliance and support.

Commissioner Bunch asked why the Commission should approve innovation plans that will not necessarily fit under a new BHSA funding category.

Executive Director Ewing stated that is the question the Commission wants to engage on because it influences the staff analysis of the innovation plans that come before the Commission. There has always been a question about how counties plan to sustain their innovation plan. The question will now change to how counties plan to sustain their innovation plan under the new funding categories.

Commissioner Rowlett suggested directing staff to ensure that innovation plans address how the effort will be sustained. It is under the Commission’s purview to ask counties if they have looked at other considerations, given behavioral health reform in 2026.

Commissioner Carnevale stated the Commission wants to encourage counties to be smart and prepared when bringing their innovation plans before the Commission for approval.

Chair Madrigal-Weiss stated Commissioners have stated the need to work with counties to make recommendations for county innovation plans to dovetail into and work successfully with the BHSA. She stated the need for consistent messaging to counties.

Commissioner Chambers asked for further detail on what happens after the five years when the Commission will no longer receive the $20 million annually for innovation.

Executive Director Ewing stated the Commission's budget is determined every year by the Legislature. Proposition 1 will dedicate $20 million a year to the Commission for five years and the Governor and the Legislature will than have the option of canceling, sustaining, or growing the innovation funding. He stated there is a provision in statute that allows the Commission to repurpose the $20 million Mental Health Wellness Act funding as innovation funds. This is also subject to an annual review by the Governor and Legislature.

Commissioner Gordon stated his assumption that the elements of Proposition 1 are subject to change at any time by the Legislature, such as the workforce development piece.

Executive Director Ewing stated there is a provision in Proposition 1 that allows changes recognizing that there may be aspects of it that over time are learned should be modified. The Legislature has always at times increased funding for different areas. There is a level of flexibility in terms of making statutory changes to the MHSA that may not extend to the level of changing percentages. Often the General Fund has been used to augment funding driven by these percentages.

Commissioner Rowlett suggested that counties integrate innovation in the development of county three-year plans.

Public Comment

Stacie Hiramoto urged the Commission not to just talk to CBHDA and the counties but also to Black, Indigenous, and people of color (BIPOC) and LGBTQ communities through their community-based organizations or through the Commission Committees. Innovation funding is important not just to BIPOC and LGBTQ communities, but also to the consumer community to serve them and to utilize organizations that are run by those communities.

Stacie Hiramoto stated she wanted to make it clear that, with these remaining funds in the in-between times, REMHDCO is not opposed to counties spending the remaining innovation funding instead of on a program that cannot be continued to prevention and early intervention programs that might be cut.

Stacie Hiramoto stated many community-based organizations want to become Medi-Cal eligible, but it is important to understand that many do not want to become Medi-Cal eligible because they do not have the capacity or it would require that they change the way they provide services. This issue is not heard often enough.

Stacie Hiramoto stated REMHDCO and others are looking forward to when innovations become under the administration of the Commission. REMHDCO was disappointed that more programs serving BIPOC and LGBTQ communities were not created under innovation at the county level except for in Fresno County and others.

Stacie Hiramoto stated REMHDCO hopes that the Commission will spend innovation funding on CDEPs.

Richard Gallo echoed Stacie Hiramoto's comments. The speaker stated programs will be cut and peer support services will go away under Proposition 1. This will have negative impacts. Peers are not being valued or respected at the state level. Peers were excluded during the Proposition 1 community planning process.

Flor Yousefian Tehrani, Psy.D., Innovation Manager, Orange County, stated the system needs to be reimagined. Orange County will be bringing a proposal with five components to redesign the system. She asked for the Commission's support in helping Orange County with this large proposal.

Commissioner Discussion

Chair Madrigal-Weiss invited Commissioner Rowlett to work with staff to develop a game plan for the final phase of the MHSA innovation dollars. She asked other Commissioners who would like to work on this plan to volunteer.

9: 2023-2024 Spending Plan Update

Chair Madrigal-Weiss stated the Commission will hear a budget update and consider approval on expenditure plans and associated contracts for FY 2023-24. She asked staff to present this agenda item.

Norma Pate, Deputy Director, Administrative Services and Performance Management, provided an overview, with a slide presentation, of the state budget updates, Commission adjusted budget for 2023-24, and spending authority. She stated none of the budget cuts in the Governor's Early Action Plan affect the Commission or the MHSA Fund. The Governor is also encouraging state workers to return to the office at least two days a week starting in June.

Deputy Director Pate stated the Commission approved $500,000 last year for an Innovation Summit but did not reach a contract agreement to allocate the funds, so those funds were shifted to this year. Staff is in the process of negotiating this work and plans to allocate those funds this fiscal year.

Deputy Director Pate stated the Commission received and scored over 200 applications for the CYBHI Grant Program. She thanked Deputy Director Tom Orrock and Riann Kopchak, Chief of Community Engagement and Grants, for the hard work that they and their team did on this project. The Commission will receive $15 million in technical assistance funds to administer these grants. Stanford University and UC Davis have each received a $5 million allocation from the Commission to provide technical assistance to the allcove and early psychosis programs. Approximately $5 million remains in the fund. Staff will come back to the Commission with a plan on how to allocate those funds to best administer this program.

Commissioner Comments & Questions

Commissioner Carnevale referred to the $500,000 Innovation Line Item in the Commission's Adjusted Budget slide and stated the idea was originally to hold a summit, but it was determined that holding a summit without doing advance work would

not result in transformative change. Staff has met with many organizations to learn the best approaches to innovation and now is planning to partner with both the public and private sectors, which is more relevant than ever when faced with the state budget crisis.

Commissioner Carnevale stated California has the greatest innovation engine in the world in Silicon Valley. Connecting innovations to state needs and better understanding how to meet those needs in the behavioral health system through the mechanisms in Silicon Valley creates tremendous opportunity for both a cost-effective approach and innovations that can add to the Commission's current transformational programs.

Vice Chair Alvarez asked about the Commission's role in working with the organizations that are receiving the spending authority, particularly because many of the priorities that these contracts are advancing align with the Commission's work. She asked about the opportunity to weigh in on the use of those funds.

Deputy Director Pate stated the appendices section of the strategic plan includes sharing learnings, outcomes, and challenges of the Commission's projects and initiatives with the Commission and community partners and gathering community feedback on projects underway.

Chair Madrigal-Weiss stated there are partnerships the Commission has been involved in for a while. She asked if the Commission will continue to fund similar partnerships. She asked about outcomes and how the Commission can not only fund projects but help inform them.

Executive Director Ewing stated the Commission's budget is significant, complex, and works across multiple fiscal years. In many of these areas, staff participates in conversations around goals and strategies or brings in outside subject matter experts in support. There are other areas where staff is not as actively involved to avoid influencing how funds are used, such as in community advocacy. He stated staff capacity makes it difficult to attend all meetings. He welcomed direction from Commissioners on areas where staff should be more actively involved, but noted that staff is best with areas where they have expertise.

Commissioner Rowlett referred to the spending authority for the FSP evaluation, which requires a smaller amount of funding. He stated Commissioners have the responsibility to ask questions as it relates to all areas of the Commission's budget but especially areas where Commissioners have experience. He asked for verification that, because staff did not have the expertise, Third Sector and Healthy Brains were identified to put together an evaluation and then funds will be allocated based on the Commission's approval to get that work done.

Executive Director Ewing stated quite often the Commission facilitates quality improvement. The Ballmer Group funded Third Sector to support process improvements in FSPs in Los Angeles County. In response to that, other counties were interested in joining that effort and the Commission provided funds to expand the work that Third Sector was already doing on behalf of Los Angeles County. Healthy Brains was similar in that several counties have been working with them with funding from the

Commission. The counties asked for ongoing support to extend the work, which is based on outcome-based contracting.

Commissioner Chambers asked about the amount budgeted for peer respite.

Executive Director Ewing stated the Commission receives $20 million per year under the Mental Health Wellness Act Fund, and has worked over the years to expand flexibility in how those funds are used. Originally it was only available for crisis response in partnership with county behavioral health departments. Statutorily, the Legislature responded by allowing those dollars to be used more flexibly for crisis prevention, intervention, and response, and to work with a diverse group of partners, counties, and others. Staff had asked the Commission to prioritize areas for investment. Peer respite is one of the areas identified. It is up to the Commission to determine investments to be made; investments in the past have been between $10 million and $20 million.

Commissioner Chambers commended former Commissioner Khatera Tamplen for uplifting peer respites. Peer respites and other least-restrictive crisis settings are important.

Commissioner Robinson asked about expected budget impacts to the Commission, given the state's budget deficit.

Deputy Director Pate stated the Commission has not been impacted at this time. The proposed budget is the same with ongoing funds to be spent over multiple years. She stated she will provide an update report after the Governor's May Revise.

Public Comment

Stacie Hiramoto commended Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners for asking good questions. She stated she would love for the Commission to have more involvement or to at least monitor projects.

Stacie Hiramoto asked that staff ensure, when executing contracts, that reducing disparities and the ability to serve BIPOC and LGBTQ communities are always brought to the forefront. She stated the hope for more research or interaction besides just having a diversity, equity, and inclusion statement on contractor websites, but ensuring that the contractor staff and boards include individuals from diverse communities representing all the people of the state, and that specific staff from these organizations working on projects with the Commission are representative of the diverse communities of this state.

Stacie Hiramoto stated REMHDCO believes that the Commission has a large enough staff and budget to consider having an expert on staff in matters of diversity, equity, and inclusion to review processes, contracts, etc. While REMHDCO believes Commission staff may be committed to serving BIPOC and LGBTQ communities, not all may be skilled in understanding how to evaluate and monitor whether a contracted organization is able to serve these communities.

Commissioner Discussion

Chair Madrigal-Weiss asked staff to explore options with budget partners to support Stacie Hiramoto's comments. It is important to work with partners that support not only the Commission's strategic plan but also its mission, vision, and principles.

Action: Chair Madrigal-Weiss asked for a motion to approve the revised Fiscal Year 2023-24 spending plan. Commissioner Carnevale made a motion, seconded by Commissioner Bunch, that:

- *The Commission approves the revised Fiscal Year 2023-24 spending plan.*

Motion passed 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

10: Legislation

Chair Madrigal-Weiss stated the Commission will consider legislative priorities for the current legislative session. She asked staff to present this agenda item.

Kendra Zoller, Deputy Director of Legislation, introduced the speakers who will be presenting on these items.

- Assembly Bill 2352 (Irwin), relating to psychiatric advance directives

Kiran Sahota, President, Concepts Forward Consulting, and Lead Project Director, MHSA Multi-County Psychiatric Advance Directives (PADs) Innovation Project, thanked the Commission for approving the initial phase of the PADs Project in 2021. This bill seeks to build out a legal framework for PADs in California, which will work in tandem with a pilot project already underway in seven counties across the state to expand use of PADs and ensure access to first responders and health care professionals.

Ms. Sahota reviewed the goals, objectives, and directives of the project and noted that AB 2352 recognizes a stand-alone PAD as a document that reduces stigma of a behavioral health condition, creates accessibility and inclusion for all individuals, and acknowledges the need for digital transformation and the role of a trusted outreach worker or Peer Support Specialist in facilitating and witnessing this document.

Ms. Sahota stated a crucial aspect of AB 2352 is emphasizing the importance of reducing recidivism of incarceration and hospitalizations through personalized care and sensitivity and underscoring the potential impact of a stand-alone PAD on improving outcomes for individuals experiencing a behavioral health crisis. The next phase of this project includes live testing. She asked for the Commission's support for AB 2352.

Commissioner Comments & Questions

Commissioner Brown asked about the mechanism of the directives and how they would be utilized to accomplish project goals.

Ms. Sahota stated PADs have not been utilized for over 30 years. Digital technology has been the missing piece. The digital aspect provides a connection with the California Law Enforcement Telecommunication System (CLETS), which supplies immediate access for law enforcement that is based on the consent of the individual. Individuals digitally choose the amount of personal information to be supplied. This digital technology is being considered as an avenue for law enforcement crisis teams, 988, and hospital emergency departments.

- Assembly Bill 2711 (Ramos), relating to a public health approach to suspensions and expulsions in schools

Adrienne Shilton, Senior Policy Advocate, California Alliance of Child and Family Services, stated this bill would revise school suspension and expulsion policies for drug-related infractions by requiring local education agencies to create policies using a public health approach, in lieu of suspensions and expulsions. She provided an overview, with a slide presentation, of the issue that AB 2711 is trying to solve.

Danny Thirakul, Policy Coordinator, California Youth Empowerment Network (CAYEN), continued the slide presentation and discussed what the data shows. He stated CAYEN is looking to reduce substance use among youth and ensure that youth receive the services and supports they ask for, such as information, resources, and direct engagement with understanding. He stated there is currently no standard to ensure that youth receive those services and supports; instead, youth are being punished. The Education Code allows student officials to use discretion in determining whether to suspend or expel youth – this discretion is applied unevenly and does not give students what they need and ask for. AB 2711 ensures that California has a standardized process, that suspensions and expulsions are used equitably, and that services and supports are delivered to youth.

Ms. Shilton continued the slide presentation and discussed the objectives of AB 2711. She stated the bill will shift how schools respond to the substance use crisis amount youth. The bill will ensure that supportive services are offered first and that schools will document those attempts. She stated the bill sponsors have been talking to schools about successful approaches and how to better support youth. This engagement has strengthened the proposal this year. She asked for the Commission's support for AB 2711.

Commissioner Comments & Questions

Commissioner Danovitch stated he personally supports this bill. He stated, when talking to school administrators about the rationale for zero tolerance, the rationale always centers around creating a safe environment and protecting other children. He asked how AB 2711 deals with the issue of intent to distribute to other children.

Ms. Shilton stated AB 2711 does not address the selling of drugs but deals with possession and use. The bill does not take away an administrator's ability to remove a student if the student is actively using or actively under the influence. The bill strikes a balance between autonomy for school administrators to deal with immediate health and safety concerns and disproportionate suspensions and expulsions.

Commissioner Danovitch stated he used the term "distribute" rather than "sell" because it may have nothing to do with sales. He noted that fentanyl overdoses in schools often stem from one source. He stated that is the only source of opposition to this bill he can imagine. He suggested including a game plan to deal with that.

Commissioner Gordon stated he personally supports this bill. He stated his only concern is for the smaller school districts. Generally, smaller districts have very few individuals on site and on scene to handle these issues. He asked if there is some accommodation that can be made to put the onus on other bodies in the vicinity of a

smaller school district to be on hand to help execute this. He noted that the process proposed in AB 2711 is certainly preferable to exclusion, but school districts need a fair chance to execute it.

Ms. Shilton offered to work on that language with Commissioner Gordon. Although this has been heard from schools during the statewide engagement process, bill language has not yet addressed it.

Commissioner Gordon stated he would be happy to help with the language.

Commissioner Rowlett agreed with Commissioner Gordon that there is a problem but the intervention being used is not working. He stated his enthusiasm about addressing the suspension rates in the BIPOC community. Even school districts that are resourced often have unique challenges associated with the expectation that they provide students with appropriate resources, as directed in AB 2711. Since suspension does not work, as evidenced by the data presented, there is an opportunity to be more innovative with strategies, such as using community-defined practices. These practices are typically resourced in communities that have a wide array of behavioral health or substance use services. He stated the need to consider alternatives for the communities identified in the data that do not have these resources available to them.

Commissioner Rowlett stated including helping families with innovative resources is important. How to engage families more effectively must be considered as part of the bill.

Commissioner Brown asked about a mechanism to deal with repeat offenders.

Ms. Shilton stated the bill tried to address the issue that disproportionate action is taken with some children.

Commissioner Brown asked if that disproportionate action is being taken on youth who continue to bring drugs into schools.

Ms. Shilton stated data shows that children from socioeconomically-disadvantaged backgrounds are disproportionately impacted – kids of color, particularly boys of color, homeless youth, and foster youth. An approach can still be suspension or expulsion in this bill, but the bill requires a conversation first about what is happening with this child, what they need, on- and off-campus resources that are available, and community-based providers that can provide support.

Commissioner Brown stated he is whole-heartedly in support of that. He asked about youth who become a chronic issue, which impacts the child’s safety and the safety of the other children in the school.

Ms. Shilton stated a balance had to be struck to allow for suspension and expulsion.

Commissioner Bunch stated she strongly supports the bill. She asked if psychoeducation for children and their families can be added into the bill.

Ms. Shilton stated a Code section is currently being amended that lists supports that can be offered. She agreed to add psychoeducation in that list of supports.

Commissioner Chambers asked about the research. She asked if children from socioeconomically-disadvantaged backgrounds who are disproportionately impacted are using more drugs than others.

Ms. Shilton stated they are not. The data highlighted in the presentation slides shows that drug use across race and ethnicity is equal. The issue is that there is disproportionate punishment to these populations.

Commissioner Chambers stated appreciation that the bill is trying to address structural racism relative to substance use. She stated the hope that this bill includes data collection.

Chair Madrigal-Weiss thanked Commissioner Chambers for pointing out this example of structural racism. It is important to bring it up when relevant.

Chair Madrigal-Weiss stated she personally supports this bill. She stated the importance of talking about the quality of the programs in schools. She referred to the outcomes slide and asked about the bill's prohibiting a pupil who discloses their use of tobacco when seeking help from being suspended solely for that disclosure. She asked why the bill stops at tobacco and does not include marijuana or alcohol.

Ms. Shilton stated bill proponents tried to include controlled substance language, but it did not get through the Legislative Committee and Amendment processes.

Commissioner Bontrager asked about obligations imposed on schools to identify service providers. He noted that there are not a lot of SUD youth treatment providers in California's Rural North.

Ms. Shilton stated the bill is silent on this issue. It is left open for schools to determine how they arrange for these services. It could be school staff, the county, or partnerships with community-based organizations. She stated the hope that this bill will spur discussion at the school level about resources available in the community. She noted that community-based organizations are in every county in the state. Other provider associations are also doing this work that want to partner with or actively contract with schools. She stated the importance of looking beyond the walls of the school to discover local resources that can be brought in to help support children and youth.

- Senate Bill 1318 (Wahab), relating to youth suicide crises response in schools

Carson Knight, Legislative Aide with Senator Wahab, introduced SB 1318.

Amanda Dickey, Executive Director of Government Relations, Santa Clara Office of Education, thanked the Commission for its leadership in focusing on youth mental health, in particular youth mental health integrated in schools. She noted that schools appreciate the work of the Commission, which has been fundamental in pushing forward many of the initiatives from the Administration.

Ms. Dickey introduced SB 1318 and stated the bill requires the Department of Education to revise their model policy, which came out during the COVID-19 pandemic without community input, and requires local educational agencies (LEA) to adopt a youth suicide crisis intervention protocol that prioritizes mental health professionals first and limits involvement and notification to law enforcement.

Commissioner Comments & Questions

There were no questions from Commissioners.

- Senate Bill 1472 (Limon), relating to a firearm do not sell list

Commissioner Brown offered SB 1472 for consideration for endorsement today. He stated this bill was proposed as a result of a suggestion made to the Commission during public comment a few meetings ago. SB 1472 establishes a Do Not Sell list for firearms that individuals can voluntarily put themselves on and take themselves off. The benefit would be if someone is having suicidal ideation and recognizes the potential for them to purchase a firearm to use in suicide. This bill would be a mechanism to stop the sale of that firearm. It is sponsored by the California State Sheriff's Association and co-sponsored by the California Association of Psychiatrists.

Commissioner Comments & Questions

Commissioner Bunch asked about requirements for an individual to remove their name from the list.

Commissioner Brown stated adding and removing a name is voluntary. He stated Washington, Virginia, and Utah have similar laws.

Chair Madrigal-Weiss asked about the holder of the list.

Commissioner Brown stated the list will be held by the Department of Justice.

Public Comment

Marika Collins, Director of Public Policy and Advocacy, Didi Hirsch Mental Health Services, spoke in support of AB 2711. The speaker referred to SB 1318 and stated the need to ensure that students are referred to 988 crisis counselors when referencing 988 as a resource for students.

Deb Roth, Senior Legislative Advocate, Disability Rights California (DRC), stated DRC opposes AB 2352. The speaker stated DRC would like to get to a support position but, despite substantial amendments, the bill is still not peer friendly in key areas. In describing legislative and policy advocacy, the project materials say, "consumer voices will be in the lead to create a legal structure to recognize and enforce PADs." This has not happened. The speaker stated, although they are a member of an ad hoc legislative advisory committee for the bill, they did not receive the bill language before it was introduced. The bill's proponents have not articulated how they intend PADs to be used in a crisis or the obligations of law enforcement, first responders, and hospitals. Law enforcement has never had access to an advanced directive. There is much work to be done. The speaker asked the Commission to support this bill with direction to formally partner with the DRC and other interested peer groups.

Mark Karmatz, consumer and advocate, asked if 988 has ever been used for referral for services for suicidal ideation. If not, why not?

Stacie Hiramoto thanked Deb Roth for her comments. She stated she will take a closer look at AB 2352. She thanked the Commission for considering AB 2711 and thanked the sponsors of the bill for not giving up last year and for working hard to get the bill passed. She stated the REMHDCO strongly supports AB 2711.

Stacie Hiramoto thanked and commended Kendra Zoller for her willingness to meet with and share information with people in the community. The REMHDCO has been facilitating a forum since 2007, where representatives from government and community at state and local levels gather to discuss any policy issue related to the MHSA. She stated, since Ms. Zoller's hire, she has been willing to attend these meetings and share information that is helpful and appreciated. It is important for Commissioners to know how Ms. Zoller embodies and models the spirit of the MHSA.

Commissioner Discussion

Chair Madrigal-Weiss stated she will entertain motions per legislation.

AB 2711

Action: Chair Madrigal-Weiss asked for a motion to support AB 2711. Commissioner Danovitch made a motion, seconded by Chair Madrigal-Weiss, that:

- *The Commission supports AB 2711 and directs staff to communicate its position to the Governor and the Legislature.*

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, Danovitch, Gordon, Robinson, and Rowlett, and Chair Madrigal-Weiss.

SB 1318

Action: Chair Madrigal-Weiss asked for a motion to support SB 1318. Commissioner Gordon made a motion, seconded by Commissioner Rowlett, that:

- *The Commission supports SB 1318 and directs staff to communicate its position to the Governor and the Legislature.*

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, Chen, Danovitch, Gordon, Robinson, and Rowlett, and Chair Madrigal-Weiss.

AB 2352

Chair Madrigal-Weiss asked that Commissioner Chambers provide guidance to staff while engaging on this, ensure that the Commission is working with disability rights groups, and ensure that it empowers peers and supports recovery. It is important to be intentional about the language in this bill.

Action: Chair Madrigal-Weiss asked for a motion to support AB 2352. Commissioner Chambers made a motion, seconded by Commissioner Bunch, that:

- *The Commission supports AB 2352, directs staff to communicate its position to the Governor and the Legislature, directs Commissioner Chambers to provide guidance to staff while engaging on this, ensures that the Commission is working with disability rights groups, and ensures that the bill empowers peers and supports recovery.*

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, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

SB 1472

Action: Chair Madrigal-Weiss asked for a motion to support AB 1472. Commissioner Carnevale made a motion, seconded by Commissioner Gordon, that:

- *The Commission supports SB 1472 and directs staff to communicate its position to the Governor and the Legislature.*

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, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

11: Strategic Plan

Executive Director Ewing tabled the discussion on this agenda item to the next meeting. He stated staff direction from Commissioners was to develop a strategy for periodic progress reports on the goals outlined in the strategic plan. Staff spent time thinking about key metrics to use to report impacts. He asked Commissioners to review the material provided in the meeting packet.

12: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place in Sacramento on May 23rd, where the Commission will continue the discussion of the impact of the reforms in the BHSA with a focus on FSPs. There being no further business, the meeting was adjourned at 2:54 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 1

Date: April 25, 2024

Proposed Motion:

The Commission approves the February 22, 2024, Meeting Minutes, as presented.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Robinson

Motion carried 9 yes, 0 no, and 3 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☐	☐	☒	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☒	☐	☐
10. Commissioner Gordon	☐	☐	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 2

Date: April 25, 2024

Proposed Motion:

The Commission adopts the amendments to the Conflict of Interest Code as presented in Agenda Item 5 and authorizes the Executive Director to initiate the Rule Making Process prior to filing the Code with the Fair Political Practices Commission.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Danovitch

Motion carried 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 3

Date: April 25, 2024

Proposed Motion:

The Commission approves the revised Fiscal Year 2023-24 spending plan.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Bunch

Motion carried 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 4

Date: April 25, 2024

Proposed Motion:

The Commission supports AB 2711 and directs staff to communicate its position to the Governor and the Legislature.

Commissioner making motion: Commission Danovitch

Commissioner seconding motion: Chair Madrigal-Weiss

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

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☐	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 5

Date: April 25, 2024

Proposed Motion:

The Commission supports SB 1318 and directs staff to communicate its position to the Governor and the Legislature.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Rowlett

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

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☐	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 6

Date: April 25, 2024

Proposed Motion:

The Commission supports AB 2352, directs staff to communicate its position to the Governor and the Legislature, directs Commissioner Chambers to provide guidance to staff while engaging on this, ensures that the Commission is working with disability rights groups, and ensures that the bill empowers peers and supports recovery.

Commissioner making motion: Commissioner Chambers

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	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
April 25, 2024

Motion #: 7

Date: April 25, 2024

Proposed Motion:

The Commission supports SB 1472 and directs staff to communicate its position to the Governor and the Legislature.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Gordon

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

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

May 23, 2024, Commission Meeting

Transformational Change: Full-Service Partnerships

Summary: The Commission will hear from a representative from the Department of Health Care Services and a county behavioral health director who will share perspectives on ways to drive improvement in Full-Service Partnership service delivery and outcomes. The Commission will also hear findings from research partners on their community engagement efforts to identify key areas of focus to meet the technical assistance and capacity building needs of FSP service providers. Finally, Commission staff will present next steps regarding the previously allocated $20 million in MHWA funds.

Background: FSPs are a critical component of the mental health treatment continuum, designed to wrap services and supports around individuals with serious mental health challenges to keep them out of the hospital, the criminal justice system, and the streets. The original Mental Health Services Act recognized the importance of FSPs in directing counties to allocate most of the MHSA Community Services and Supports (CSS) funds to FSPs. Prop 1 maintains FSPs as essential to the continuum and expands eligibility for services to those individuals with substance use disorder diagnoses.

SB 465 (2021) charges the Commission with biennial reporting to the legislature on the performance and impact of FSPs. FSPs represent a "whatever it takes" model to support, sustain, and improve the life outcomes of people with serious mental illness. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration, and hospitalization across the state, FSPs experience challenges with workforce, access, quality, and performance management.

Since our initial report in 2022, we have done extensive community engagement to better understand the needs of counties to drive the kind of systemwide improvement necessary to move the needle on hospitalization, homelessness, and incarceration for Californians with serious mental illness. This includes: 1) conducting deep dives of current contract management practices with several counties; 2) hosting numerous listening sessions, focus groups, and interviews to better understand FSP service delivery; and 3) fielding a statewide survey of county behavioral health staff to identify ways to improve outcomes for FSP partners. In addition, we have conducted site visits to an adult FSP and to a youth FSP.

In February, the Commission approved setting aside $20 Million in Mental Health Wellness Funds to improve service delivery and outcomes for Full-Service Partnerships. Through site visits and statewide engagement efforts, the following workstreams were identified:

- Sustainable funding: restructure current funding models to increase efficiency and impact
- Workforce and capabilities: Supporting innovative workforce development solutions
- Accountability: Define success, develop metrics, and identify key client outcomes; and improve data collection and standardize reporting statewide
- Infrastructure: Strengthen current service delivery models connected to the broader continuum of care

Next steps are to determine a strategy and procurement process for the multi-year, $20 million technical assistance, and capacity building initiative.

Presenters: Emily Melnick, Director Third Sector; Richard Johnson, CEO Healthy Brains Global Initiative; Jonathan Sherin, Chief Medical Officer, Healthy Brains Global Initiative; Susan Holt, Behavioral Health Director, Fresno County; Tyler Sadwith, State Medicaid Director, Department of Health Care Services.

Enclosures (7): (1) Panelist Bios; (2) Briefing Memo; (3) HBGI Report summary; (4) Third Sector Report Summary; (5) HBGI Slide Summary: Towards a New Contracting Model for Full-Service Partnerships; (6) HBGI Report: Towards a New Contracting Model for Full-Service Partnerships; (7) Invitation Letters

Handouts (1): (1) PowerPoint Presentations

Mental Health Services
Oversight & Accountability Commission

Transformational Change: Full Service Partnerships
Presenter Biographies
May23rd, 2024

Emily Melnick, Director Third Sector Emily is a Director based in Brooklyn. She is a social impact strategist with experience in program design, technical assistance, and philanthropy. She comes to Third Sector from the Corporation for Supportive Housing (CSH), where she led work to improve housing stability for people with HIV and for older adults. Before CSH, Emily was a consultant at The Bridgespan Group, where she focused on economic mobility, philanthropy strategy, and the arts. Emily previously was a Director of Institutional Development at Gay Men's Health Crisis, an AIDS service organization in NYC, where she developed GMHC's housing, economic mobility, and gender justice portfolios.

Emily's publications include "Employment is Healthcare", presented at the American Public Health Association national meeting and "Participatory Logic Modeling: Engaging Stakeholders in Program Development and Evaluation Design" at the American Evaluation Association conference. Emily holds an MPH from Boston University School of Public Health, and a BA from Swarthmore College with a special major Deaf Studies and Theater, where she focused on theater as a vehicle for social change. She continues to work as a director and dramaturg in New York City.

Richard Johnson, CEO Healthy Brains Global Initiative Mental health has run as a theme through much of his work of the last 23 years, striving to enable socially excluded people to secure and sustain independence and healthy lives. He uses contracting and performance management to connect spending better with delivery, in order to give the service users a better, more individual and locally relevant, outcomes-focused response.

At HBGI he is bringing together an exciting, performance-focused, global team to challenge the tired delivery (and wasted funding) of so many national and international systems and institutions, to deliver more meaningful outcomes for more vulnerable people limited by poor mental health (and social exclusion).

Richard spent two years as a Senior Advisor for the Global Fund (HIV, TB and malaria). He mobilized a number of projects, including: incentivizing informal medicine vendors to extend malaria testing and treatment in rural areas of Nigeria; introducing incentives to increase TB reporting by private pharmacies in the Philippines, and; linking the payments of community health workers to their performance to increase HIV treatment adherence in Niger.

He worked for nearly ten years as a Senior Consultant for the World Bank. Until the resurgence of the Taliban, he was supporting the Ministry of Public Health in Afghanistan with the management of contracted health services in which service provider payments were tied to the

delivery of key health interventions. Other projects, across a number of countries, have included: linking refugees with jobs in Ethiopia, and; designing and mobilizing outcomes-based job intermediation for long-term unemployed people in Saudi Arabia.

He continues to oversee and advise on the delivery of social impact programs. He is Chair of a youth employment Development Impact Bond in Palestine and a similar Social Impact Bond in South Africa. He has previously chaired nine Social Impact Bonds in the UK, which targeted homelessness, care for carers and refugees.

Previously, Richard set up and ran a series of high-performing private employment service providers in the UK under contract with the government there – paid on the basis of outcomes. His last contract was worth £750 million over seven years, assisting long-term unemployed people, many of whom had poor mental health, to find employment.

Previously Richard had established one of the first Employment Zones – the first large scale outcome-based contracts in the UK – in an area of chronically high deprivation. He worked as an advisor to service providers in Australia, assisting people with disabilities to secure jobs. He was a Specialist Advisor to the UK government's Work and Pensions Select Committee.

Richard had an early career in international education (in Sudan, Northern Cyprus, Greece and the UK). He studied Philosophy and Psychology at Oxford University and Applied Linguistics at Exeter University

Jonathan Sherin, M.D., Ph.D., Chief Medical Officer Healthy Brains Global Initiative Dr. Sherin was formally the Director of the Los Angeles County Department of Mental Health. Dr. Jonathan Sherin is a longtime well-being advocate who has worked tirelessly throughout his career on behalf of vulnerable populations in public and private sectors. He is currently the Chief Medical Advisor for Healthy Brains Global Initiative. In his former role as Director of the Los Angeles County Department of Mental Health (LACDMH), he oversaw the largest public mental health system in the United States with an annual budget approaching $3 billion.

Prior to joining LACDMH, Dr. Sherin served for over a decade at the Department of Veterans Affairs (VA) where he held a variety of clinical, teaching, research, and administrative positions as well as academic appointments. In his last such post, Dr. Sherin directed mental health for the Miami VA Healthcare System and served as vice-chairman for the Department of Psychiatry and Behavioral Sciences at the University of Miami.

Dr. Sherin completed his undergraduate study at Brown University, his graduate work at the University of Chicago and Harvard Medical School, and his residency in psychiatry at UCLA

Susan Holt, Behavioral Health Director, Fresno County Susan Holt, Licensed Marriage and Family Therapist, serves as the Director of Behavioral Health and Public Guardian for Fresno

County. She has worked in the behavioral health field for over 25 years in various roles including manager, clinical supervisor, and clinician providing direct mental health treatment services with adults, children, and families. She has clinical experience working in settings such as a residential treatment program for adolescents, a foster family agency, public schools, and an inpatient psychiatric hospital. Her passion in behavioral health leadership is to cultivate strengths within teams to create and support environments that promote well-being, resilience, and recovery.

Tyler Sadwith, State Medicaid Director at the Department of Health Care Services Tyler Sadwith was appointed Deputy Director of Behavioral Health at the California Department of Health Care Services (DHCS) by Governor Newsom in June 2022. Tyler is responsible for leading DHCS' ambitious agenda to ensure high-quality and accessible specialty mental health and substance use disorder services in Medi-Cal and other public programs. He leads the development and implementation of policy and initiatives designed to strengthen behavioral health care access, quality, service delivery, and achieve equitable health care outcomes for 15.4 million Medi-Cal members and Californians served through other programs. He provides direct management to four divisions: Community Services, Licensing and Certification, Medi-Cal Behavioral Health Oversight and Monitoring, and Medi-Cal Behavioral Health Policy.

Prior to his appointment, Tyler served as Assistant Deputy Director of Behavioral Health at DHCS, assisting to oversee the planning, implementation, coordination, evaluation, and management of the Department's behavioral health services. Tyler was a Senior Consultant at Technical Assistance Collaborative, Inc., where he provided strategic advice and technical support to state health leaders on behavioral health policy and delivery system reforms. Additionally, he served as Technical Director at the Centers for Medicare & Medicaid Services (CMS), where he spearheaded efforts in supporting states to introduce comprehensive benefit, program, and delivery system reforms through Medicaid Section 1115 substance use disorder (SUD) demonstration waivers. He also implemented the agency's opioid strategy and oversaw the SUD portfolio of CMS' Medicaid Innovation Accelerator Program, a cross-agency strategic 3 support and technical assistance platform designed to support service delivery and payment innovation in Medicaid.

Tyler earned a Bachelor of Arts degree in History from Reed College.

Mental Health Services
Oversight & Accountability Commission

Transformational Change: Full Service Partnerships
Briefing Memo
May 23rd, 2024

SUMMARY

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a serious mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSPs are core investments of the Mental Health Services Act and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

SB465 (2021) charges the Commission with biennial reporting to the legislature on the performance and impact of FSPs. In our first report to the legislature we highlighted three primary concerns: including underutilization, lack of resources including technical assistance, and data quality challenges. In April of 2023 we hosted a panel to share the numerous challenges facing FSP service providers including lack of sustainable workforce, and lack of clarity and guidance to improve service delivery. Since our initial report we have done extensive community engagement to better understand the needs of counties to drive the kind of systemwide improvement necessary to move the needle on hospitalization, homelessness, and incarceration for Californians with serious mental illness. This includes: 1) conducting deep dives of current contract management practices with several counties; 2) hosting numerous listening sessions, focus groups, and interviews to better understand FSP service delivery; and 3) fielding a statewide survey of county behavioral health directors to identify ways to improve outcomes for FSP partners. In addition, we have hosted an FSP panel and conducted site visits to both a youth/TAY and adult FSP.

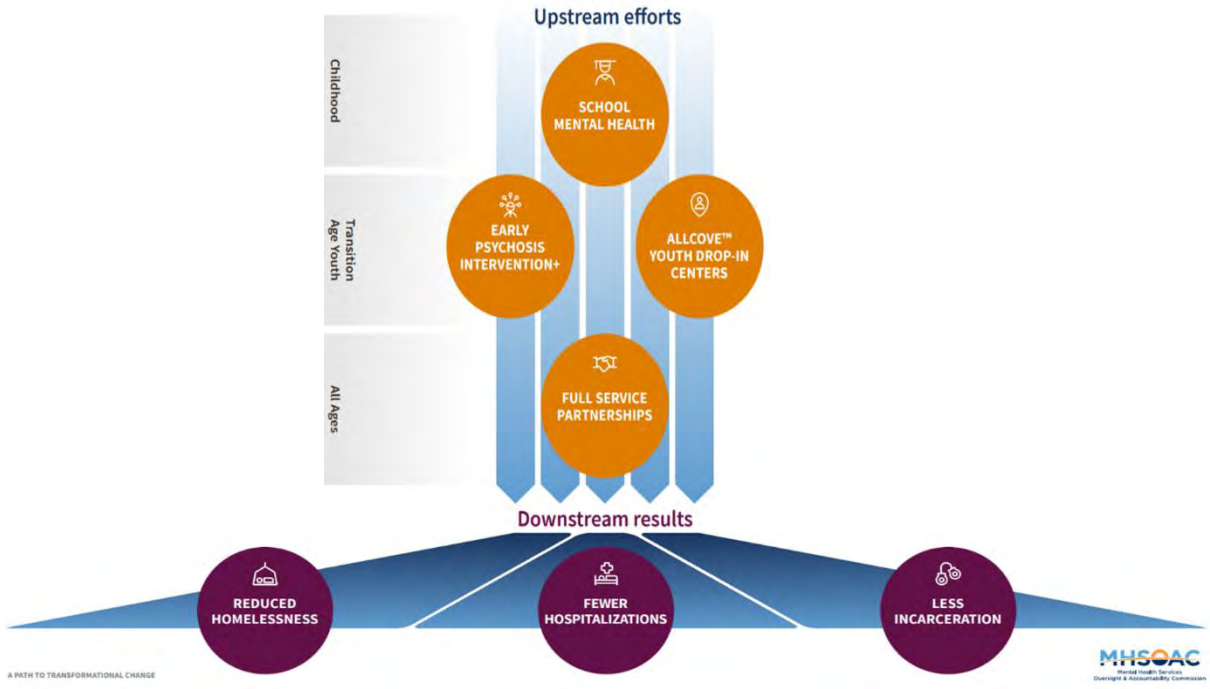
Our directive from the legislature in combination with the learnings from our community engagement efforts motivate our continued dedication to improving FSPs. The passing of Prop 1 presents a key opportunity to catalyze improvement in FSP service delivery and quality. As such, the Commission has set aside $20 million from Mental Health Wellness Act fund to explore the following solutions:

- Sustainable funding: Restructure current funding models to increase efficiency and impact
- Workforce and capabilities: Supporting innovative workforce development solutions
- Accountability: Define success, develop metrics, and identify key client outcomes; and improve data collection and standardize reporting statewide
- Infrastructure: Strengthen current service delivery models connected to the broader continuum of care

Mental Health Services
Oversight & Accountability Commission

Background

Currently, 35% of California's MHSA revenue is dedicated to Full Service Partnerships (FSPs). FSP programs are comprehensive services targeted to individuals with severe mental illness who are at risk of becoming unhoused, have a history of criminal justice involvement, or who have experienced repeat hospitalizations. FSP programs were designed to serve people in the community rather than in state hospitals or jails. As such, FSPs serve as upstream efforts to reduce hospitalization, incarceration, and homelessness.



The name – Full Service Partnership – reflects the goal of developing a "whatever it takes" partnership between the person being served and the service provider. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs experience challenges meeting the growing need for services.

Increasing need

- In 2020, approximately 37,000 unhoused Californian's were living with mental illness and a similar number were living with chronic substance use disorder.
- Nearly 80% of unhoused individuals in California have a previous incarceration, and approximately 30% had been detained during their most recent experience of

homelessness. This suggests a strong relationship between living unhoused and being involved in the criminal justice system.

- Approximately 30% of individuals incarcerated in the state and county level were either in need of mental health services or actively receiving psychotropic medication.
- In 2022, more than 1,700 individuals who were found incompetent to stand trial were being held in jail while on the waitlist for treatment at a state hospital. The cost of treating individuals in jails to restore them to competency was about $172 million.
- Those who are moved off the waitlist, are sent to one of five state hospitals that serve more than 6,200 individuals. The cost to run these five hospitals exceeds $2 billion annually.

The increasing number of unhoused residents, long waiting lists to enter state hospitals, and ongoing reliance on local law enforcement and community hospital care suggest the need for high-quality FSP programs is greater than ever.

Our Efforts

SB465 (2021) charges the Commission with biennial reporting to the legislature on the performance and impact of FSPs. Since our initial report we have done extensive community engagement to better understand the needs of counties to drive the kind of systemwide improvement necessary to move the needle on hospitalization, homelessness, and incarceration for Californians with severe mental illness. This includes: 1) conducting deep dives of current contract management practices with several counties; 2) hosting numerous listening sessions, focus groups, and interviews to better understand FSP service delivery; and 3) fielding a statewide survey of county behavioral health directors to identify ways to improve outcomes for FSP partners. In addition, we hosted an FSP panel and conducted site visits to both adult and youth FSPs.

These efforts have highlighted the need for a technical assistance and capacity building strategy to improve statewide outcomes for those eligible and/or receiving FSP services.

As mentioned, the strategy will focus on the following four key foundational levers:

- Sustainable funding
- Workforce and capabilities
- Accountability
- Infrastructure

Our directive from the legislature in combination with the learnings from our community engagement efforts motivate our continued dedication to improving FSPs. The passing of Prop 1 presents a key opportunity to catalyze improvement in FSP service delivery and quality. However, if we are to leverage FSPs to reduce the negative outcomes of homelessness,

incarceration, and hospitalization across the state it is going to require a strong infusion of financial support, innovation, and unparalleled collaboration.

Staff are currently working to determine a strategy and procurement process for the multi-year, $20 million technical assistance, and capacity building initiative.

Panelists

This panel seeks to highlight the vast potential to expand and fortify FSP service provision across the state, thus diverting people away from jails, hospitals, and homelessness, and improving life outcomes for many of California's most vulnerable residents.

- Tyler Sadwith, State Medicaid Director at the Department of Health Care Services
  Tyler will speak to the role of FSPs in the behavioral health continuum of care, as well as the role of DHCS in driving improvement and change in FSPs through increased accountability and transparency under Prop 1.

- Emily Melnick, Director Third Sector
  Panelist will summarize findings from Third Sector's recent community engagement work including a summary of activities and main findings and recommended next steps for better supporting FSPs.

- Richard Johnson, CEO Healthy Brains Global Initiative
  Richard Johnson will summarize findings from HBGI's consultations with state and county partners. His presentation will detail how county and state stakeholders define and measure success, use data to track and report FSP performance, currently base their contracts for service delivery, and currently execute contract and service management.

- Jon Sherin, Chief Medical Officer Healthy Brains Global Initiative
  Richard Johnson will summarize findings from HBGI's consultations with state and county partners. His presentation will detail how county and state stakeholders define and measure success, use data to track and report FSP performance, currently base their contracts for service delivery, and currently execute contract and service management.

- Susan Holt, Behavioral Health Director, Fresno County
  Susan Holt will share her perspective as a county /behavioral Health Director, including share her insights on and experience with the importance of Full Service Partnerships in the larger continuum of care, the challenges presented by current legacy data collection systems, and the need for standardization of metric and outcomes.

Mental Health Services
Oversight & Accountability Commission

Considerations for Commissioners:

• How should the Commission use its mental health leadership and advisory role to elevate and disseminate practices, policies, and programs that are effective in improving FSP service delivery and outcomes?

• How can the Commission support counties in reducing disparities in access and outcomes for culturally and linguistically diverse communities, and individuals with disabilities?

• How can the Commission support other State agencies such as HCAI and DHCS in finding scalable solutions to current challenges facing FSPs, including workforce development and data collection and reporting systems?

Transformational Change: Full Service Partnerships

HBGI Report Summary

May 23rd, 2024

Towards a New Contracting Model For Full Service Partnerships Report Summary

One key component of the MHSA is the expectation that every county will invest in comprehensive, "whatever it takes" community service strategies to meet the needs of the most seriously mentally ill persons, through what are known as Full Service Partnerships (FSPs). FSPs represent an estimated $1 billion annual investment in public funds and have tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs.

Despite the recognition of the role of FSP programs and the opportunity to improve the mental wellness of Californians with severe mental health needs, there is concern that existing contracting and management of FSPs may not be optimal to drive performance and improve outcomes of individuals receiving services through an FSP.

Early in the summer of 2023, the MHSOAC contracted the Healthy Brains Global Initiative (HBGI) to undertake a review of the current FSP contracts and to explore their performance with a particular focus on contract design and performance management. They considered if and how outcomes-based contracts could enhance the performance of FSP programs and strengthen California's behavioral health system.

Among their key observations were that FSPs provide vital assistance for people with the highest level of need. Their draft report notes highly committed and professionalized staff and some good involvement of peers.

However, they do also suggest that there are areas for improvement. First, the need to strengthen performance management and accountability. Second, the need to focus more on individual outcomes for service users, as opposed to population impact. They also note that service provisions are largely homogeneous, a sign that innovation may be stifled. Lastly, they note widespread inefficiency, with many FSPs running at around 80% of capacity.

Among their recommendations, HBGI recommend:

1. Counties should consider piloting some FSP enhancements and/or new programs, particularly on positive, purposeful outcomes such as service users securing employment.
2. Outcomes contracts could deliver results by strengthening performance management and accountability, and by focusing on individual outcomes. For example, outcomes could be standardized for individuals leaving prisons or jails and also unhoused individuals.

Transformational Change: Full Service Partnerships
Third Sector Report Summary
May 23rd, 2024

California Full Service Partnership Statewide Assessment Report Summary

The Mental Health Services Oversight and Accountability Commission (MHSOAC) partnered with Third Sector to uncover opportunities to strengthen Full Services Partnership programs across the state. FSP programs provide tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs. FSP programming, however, varies greatly from county to county, with different operational definitions and inconsistent data processes that make it challenging to understand and tell a statewide impact story.

With this challenge in mind, Thid Sector furthered the work they conducted with the Multi-County FSP Innovation project to further understand the challenges faced by providers. The aims of the project were to: 1) understand the effectiveness of FSPs across the state, and 2) develop specific recommendations for strengthening the implementation and outcomes of FSP programs across California.

To do so, Third Sector applied three different methods:

1. Conducted target outreach to community members, providers, state agencies and associations, partners in healthcare, housing, and law enforcement, and other key stakeholders to understand the strengths, barriers, and opportunities for FSPs
2. Convened three community forums online to solicit input from these same individuals familiar with FSPs on how the MHSOAC can best support local FSP programs in two areas: capacity building, and data reporting, and
3. Administered a statewide survey to build a wider understanding of the landscape of FSP programs among providers and garner information about their capacity and overall needs.

Among their findings, Third Sector found that overall, FSP programs are found to be effective in supporting individuals with serious mental illness, and while this has been credited with the flexibility and breadth of services the FSP model provides, these same strengths have also been found to be the root of some programmatic challenges. Some of these challenges include:

A. Lack of clarity around what service delivery model should be utilized by FSPs
B. Workforce shortage affects a program's ability to meet the expansive services that are offered by FSP programs
C. Limited number of resources, practices, and partnerships to engage individuals into FSP services

D. Lack of appropriate step-down options, particularly for housing
E. Disparities in the FSP experience in relation to disability, culture, ang language
F. Data collection is cumbersome and do not reflect the important metrics and outcomes
G. Missed opportunities to take advantage of the various funding streams

To meet these challenges, Third Sector through their various engagement activities offered a set of core recommendations, these include:

- Service Delivery Model
    - Establish a common set of service requirements and guidance for FSP programs on opportunities for county-level adaptations based on community need.
    - Provide counties with training and guidance on the ACT model, especially around implementation and fidelity.
- Eligibility
    - Develop standardized definitions and eligibility requirements for FSP programs that can be used by providers and those referring individuals to FSP programs.
    - Create tools for TA that can be provided to counties and providers on assessment tools for FSP eligibility.
- Engagement
    - Provide resources to help providers expand their use of funding to prioritize outreach and engagement
- Step-down
    - Work with counties to develop a tiered system for FSP care to reduce the intensity of care, while also maintaining the necessary support of clients.
    - Establish step-down planning as an important part of the FSP process
    - Develop standards and assessment tools for step-down readiness
    - Provide resources and education post-FSP to facilitate engagement in care and possible reengagement if/as needed
- Diversity
    - Provide guidance and resources to improve ADA compliance of FSP providers and settings
    - Support FSPs in building connections to providers that serve people with disabilities to improve access and co-locate services as appropriate
    - Provide resources to support language access for FSP programs, including accessing translation/interpretation services
    - Provide county-specific linguistic and cultural diversity in workforce development
    - Support FSP providers to build partnerships with local cultural and community organizations
- Funding

    - Provide clear guidance and technical assistance to counties on billing
    - Support FSP programs in billing for services such as transportation and outreach
- Data
    - Prioritize what outcomes should be tracked and what data collection should be collected
    - Provide guidance on what data should be collected and how it can be used
    - Support counties in developing data sharing agreements across agencies
    - Incentivize the use of 1-2 data platforms across counties to streamline support around usability and
    - Provide counties with accessible trainings for new staff that include the basics around data entry and usage

HBGI
Healthy Brains Global Initiative

TOWARDS A NEW CONTRACTING MODEL FOR FULL SERVICE PARTNERSHIPS

A summary of the Report

The Healthy Brains Global Initiative (HBGI) for the Mental Health Services Oversight and Accountability Commission (MHSOAC) of the State of California

December 2023

Full Service Partnerships

California's Full Service Partnership (FSP) programs are intended to be recovery-oriented, comprehensive services for individuals who are unhoused, or at risk of becoming unhoused, and who have a severe, chronic mental illness, often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve and maintain people in the community rather than to rely on state hospitals or other locked institutions. FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives.

The name – Full Service Partnership – reflects the collaborative relationship between the service provider and the service user (and, when appropriate, the service user's family). The provider plans and provides a full spectrum of community services to enable the service user to achieve their goals, with a 'whatever it takes' approach.

FSPs are core investments of the Mental Health Services Act and a key element of California's continuum of care. FSPs today represent an estimated $1 billion annual investment. As of 2020, more than 60,000 individuals were enrolled in an FSP program.

A consultation and a set of recommendations

There are concerns that current FSP performance may not be optimal. In 2023, the Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted the Healthy Brains Global Initiative (HBGI) to undertake a review of the current FSPs contracts. HBGI was tasked with exploring the performance of the FSPs, with a particular focus on contract design and performance management, and describing if and how outcomes-based contracts could enhance that performance or otherwise strengthen the behavioral health system. The subsequent HBGI Report sets out observations and recommendations with the objective of:

- Strengthening existing services.
- Increasing impact and accountability.
- Re-emphasizing recovery.
- Exploring the possibility of piloting new outcomes contracts.
- Gathering learning to inform future service enhancements.

Powerful and positive first impressions

There is a wide variety of programs with different funding sources and variation in the level of contracting between counties. The HBGI Report focuses on contracted FSPs and mainly those servicing adults. The Report notes:

- FSPs save lives.
- A mature, professional, deeply compassionate service.
- Assistance for people with the highest level of need.
- A clear, shared understanding of the desired impact.
- A demonstrable achievement of that impact.
- A strongly defined case management delivery model.
- A highly committed and professionalized staff.
- Some good involvement of peers.
- Layers of supervision and support.
- Highly detailed record keeping.
- High levels of spending/investment by the State.
- An appetite for innovation and increased impact.

There are pockets of very good practice with a small number of counties monitoring service provider performance closely and some service providers evidencing strong internal performance management systems. The overarching culture is of wanting to do the right thing for all service users. However, the observations on the following slides are true for most contracts and there was widespread recognition of and support for the Report's conclusions.

Some areas for improvement, focusing on Adult FSPs

The Report suggests that there is potential for increased impact through addressing weaknesses in four broad areas:

1. 

Service specification

2. 

Service culture

3. 

Program/system efficiency (notably underspend)

4. 

Performance management

There is one over-arching recommendation which echoes throughout the Report:

> **Measuring impact (i.e. reductions in hospitalizations, incarcerations and homelessness) is not enough. The service must aim to track, report and maximize outcomes – personal outcomes that are meaningful to the service recipients.**

Service specification

- It appears now to be a largely **homogenous service** with a fairly rigid service specification that is replicated everywhere.
- Homogeneity **limits innovation** and also **cultural adaptation** (i.e. cultural fit to each community being served).
- **Access** to the service can be **difficult** and requires someone to 'fail all the way to the bottom'.
- Services are broken down by County systems into levels/**hierarchies of need,** possibly conflicting with the fluctuating personal experience of poor mental health.
- This service targeting people with serious mental illness is **conflated** in the eyes of many people **with homelessness services.**

Service culture

- Providers, and staff, are now incentivized to do **'whatever we can bill'** rather than 'whatever it takes'.
- The **medical model focuses on people's deficits** rather than their assets/potential and their goals.
- The **professionalism** of the system can be a straightjacket, with everything done in a particular way.
- In focusing on (and reporting on) just high-level impact, meaningful **outcomes** for individuals are getting lost.
- The service addresses *people* and *place* but does not give people **purpose.**
- It is keeping people stable – and safe – but with **no progression.**

Program/system inefficiency

- There is inefficiency in the system with **58 wheels being invented** (i.e. each County operating in isolation).
- **Multiple IT systems** and double (or triple) keying.
- High **staff turnover** and low morale.
- **Peers** not utilized as powerfully as they could be.
- The service is running at **70% capacity,** with insufficient incentive for providers to address this.

Performance management

- Overall, there is a lack of **systematic performance management,** by providers and by counties.
- Performance is limited as a result of the lack of transparency and accountability, with no **open performance reporting** and comparison.
- There is no sharing of **best practice** (and no identification of bad performance).
- Attempts to use **incentive-based payments** failed because the incentives were too small and designed incorrectly.
- In most cases, supervision is the only ad hoc **quality assurance.**

The key recommendations

To strengthen existing services and gather learning to inform future enhancements, the Report makes three key recommendations:

1

Implement new performance-based pilot programs

2

Develop new performance management practices

3

Build market capacity

Pilot outcomes contracts

The Report suggests that performance could be enhanced through the use of performance-based contracts (with payments linked to outcomes). Pilots of the contracts should be designed to address each County's specific needs, but the Report describes three possible pilot programs:

1 A new **Purpose-Led Outcomes Contract**

To run parallel to current FSPs, e.g. same target group, with providers paid for each person they help to achieve a purposeful outcome, such as employment.

2 An **FSP Follow-On Program**

With a lighter touch, possibly peer-led support. Service users draw up an Action Plan, including their desired outcomes, and the provider delivers ongoing support with assistance to achieve these outcomes.

3 Two new **Place-Based Outcomes Contracts**

a) *Through-the-Gate Service* for people in jail. With the provider paid for each person post-release reconnecting outside, being accommodated and securing employment (i.e. not being reincarcerated as a result of positive reintegration).

b) *Homeless Community Cluster* (e.g. an encampment of circa 50 people). Provider engages with the community, agrees practical, measurable outcomes with them (including progression from the street) and is paid on the basis of achievement of these outcomes.

Strengthening performance management and building capacity

(with more detail in the Appendix)

There is scope to strengthen considerably the performance management of the FSP contracts.

Driving performance means identifying the program's steps along its Results Chain (inputs, outcomes, outcomes and impact) and then tracking, recording, reporting and reviewing these – with a focus on outcomes. At the moment, only impact and billable minutes are really tracked.

Each month, high performing providers and counties should:

- Produce a monthly Performance Pack.
- Hold a Performance Board.
- Review the Performance Pack and ask 'what should we do differently next month'.
- Develop a Performance Improvement Plan if needed.

The OAC and counties should also:

- Openly compare (and rank) performance across providers (and across counties).
- Replace providers who consistently underperform.
- Invest in 'market stewardship'. e.g. convening best practice sharing events and developing a strategic workforce plan.

Next steps?

Next steps should be agreed with each County and with the OAC, and will vary from place to place. Counties may wish to pick and choose from the Report's recommendations, and mobilize outcomes pilots to meet local needs or look to revise FSP contracts that are coming up for renewal (with a view to build in outcomes) or build capacity across their system in performance management. It is suggested that in Q1 and Q2 of 2024:

- Counties invite HBGI to work with their management teams (and other stakeholders) to identify priorities.
- The specification of pilot programs are developed (notably the outcomes to be delivered and the payment mechanism).
- Procurement commences for service providers, along with market engagement to build interest and capacity in potential pilot providers. New entrants to the market might be encouraged.
- Workshops on outcomes contracting and performance management are run with counties and providers, developing new 'Performance Packs' reporting on monthly activities within the programs.
- HBGI facilitate new monthly Performance Boards, with a focus on outcomes, as well as best practice sharing events across all their providers.

APPENDICES

Who are HBGI?
A 'framework' for contract evaluation and design
People, place and purpose – measuring program effectiveness
Outcomes contracts and their advantages
What makes a good 'outcome' or payment trigger?
What is performance management?
An example of a performance management system

Who are HBGI?

Accountable service delivery

The Healthy Brains Global Initiative (HBGI) was established in 2019 as a 501.c.3 not-for-profit, with the support of WHO, UNICEF, the World Bank and the Wellcome Trust, to address the global lack of understanding and services related to poor mental health - and its causes and consequences. The HBGI team has a unique depth and breadth of experience in the contracting and performance-management of life-changing services for vulnerable communities. We are using performance-based contracting to create a sea change in the scale and impact of mental health and related services - either contracting and funding directly ourselves or as a technical partner with governments. In all cases, we look to pay for results, not waste, and we generate rich 'live' data on service delivery and outcomes. HBGI is funded by philanthropy and through government contracts.

A ‘framework’ for contract evaluation and design

The Report uses this Framework to evaluate FSPs and to set out a possible purpose-led contract

1	***What does success look like?*** There is a strong, clearly articulated definition of high performance that all stakeholders buy into and understand.
2	***What is being purchased?*** Payments to service providers are tied to highly relevant and easy-to-understand deliverables that reflect high performance.
3	***At what price?*** The pricing attached to deliverables must be programmatically informed and relevant, incentivize performance and drive efficiencies.
4	***How much is paid when?*** The payment schedule balances the need for working capital with incentivizing performance.
5	***When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?*** Service users and peers are involved in the design of the program and throughout delivery.

6	***How is the target group defined and who controls referrals of service users onto the program?*** Careful delineation of the targeted population and definition of eligibility criteria maximize impact.
7	***How is frontline activity and performance recorded and facilitated?*** All activity delivered on the frontline is recorded and can be analyzed, quantitatively and qualitatively, at different levels. And this impacts positively on frontline staff.
8	***What is the performance management structure/system?*** There is a systematic review of performance.
9	***What are the consequences of under-delivery or other disagreements/violations?*** The contractual terms are clear on 'step-in rights' when performance standards are not met.
10	***What assurance model oversees performance?*** Service providers have in place a robust, systematic audit and assurance process to verify the deliverables/outcomes and service quality.
11	***How does the service commissioner (i.e. County Director) fulfill the role of market steward?*** The service commissioner thinks about how to build and support the service provider's capability.

People, place and purpose – measuring program effectiveness

Three domains to define community

Being part of a community, or simply having community in life, is a requirement for overall health and wellbeing. Human beings with strong community flourish while those without it languish. At HBGI, we use three life domains to define community (and to measure program effectiveness):

- People, or ‘someone to love’, provided, for example, through peer support, family reunification or socialization programs.
- Place, or ‘somewhere to live’, such as housing, a clubhouse or peer respite programs.
- Purpose, or ‘something to do’, which might include developing hobbies, education/training, volunteering (including providing peer support), or employment programs.

Outcomes contracts and their advantages

The Results Chain

INPUTS

e.g. training is delivered

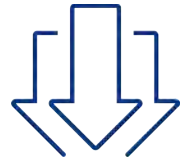
OUTPUTS

e.g. training is completed and qualifications are achieved

OUTCOMES

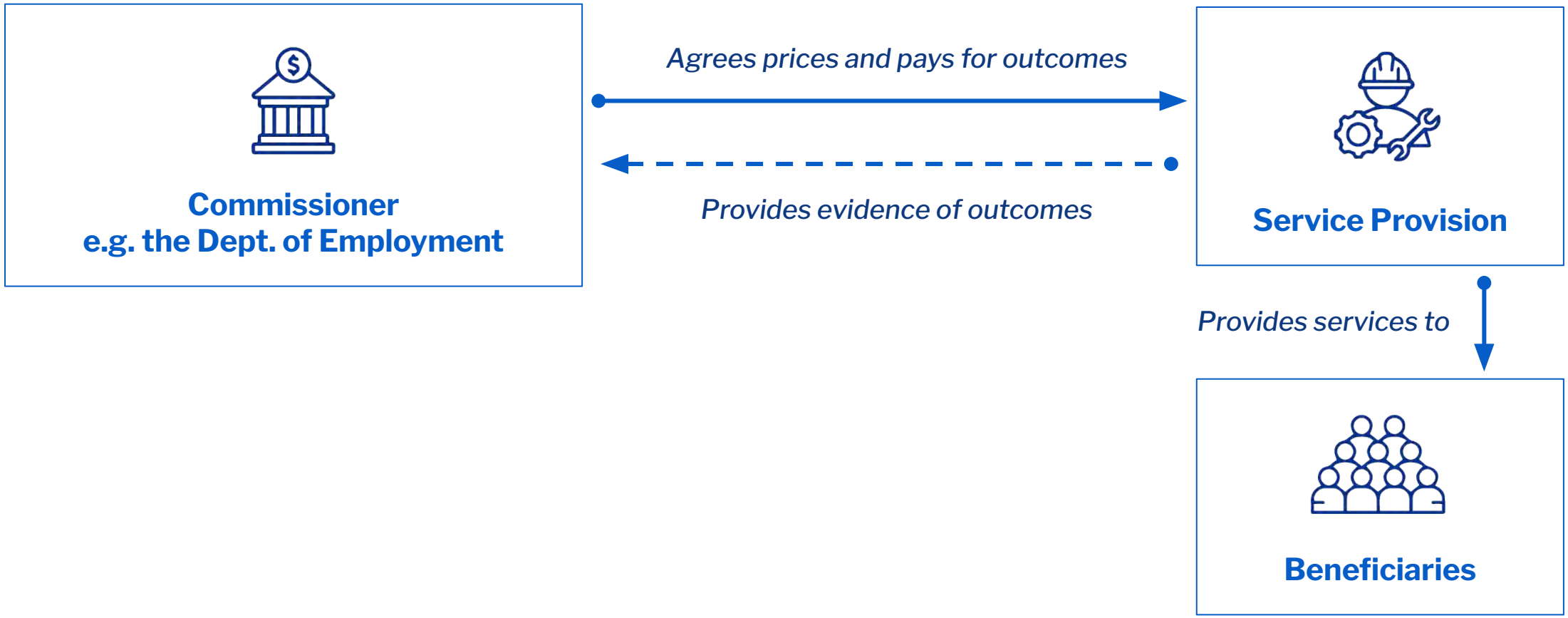
e.g. jobs are secured and sustained

IMPACT



e.g. there is a reduction in unemployment

The simple contracting relationship



A good outcomes-based model can:

- **Align incentives,** or policy with payment.
- **Change the culture,** change the language and focus.
- Increase the **quantity and quality** of performance.
- Deliver **value for money**.
- Pass the **risk of not achieving** to the service providers (or the social investors).
- Also possibly pass the **volume risk** to the service providers (i.e. reaching more excluded people).
- Address **funder fatigue**.
- Increase **transparency** over where money goes (i.e. increase accountability and exclude 'leakage').
- Focus service design on the destination and with the service user.
- Encourage an **individualized, localized approach** (and an 'asset-based approach' moving away from 'deficit' or a 'medical model').
- Enable **flexibility and incentivize innovation** (including in response to conflict).
- Create a **data rich system** because of the performance focus.

What makes a good ‘outcome’ or payment trigger?

How to maximize the incentive/reinforcement?

Agree a **clear, simple definition of success**. Define your target population. Don't prescribe the inputs. Tie the payments to activities/outcomes which are:

- Not too far down the 'results chain'.
- Clear, comprehensible (and a small number of them).
- Relevant, with 'face validity' (i.e. operationally real and linked to what success is).
- Meaningful to the service beneficiary (ideally selected by them).
- Measurable and verifiable.
- Costed with commercial nous and considerate of cashflow.

Then…….track, report and review.

What is performance management?

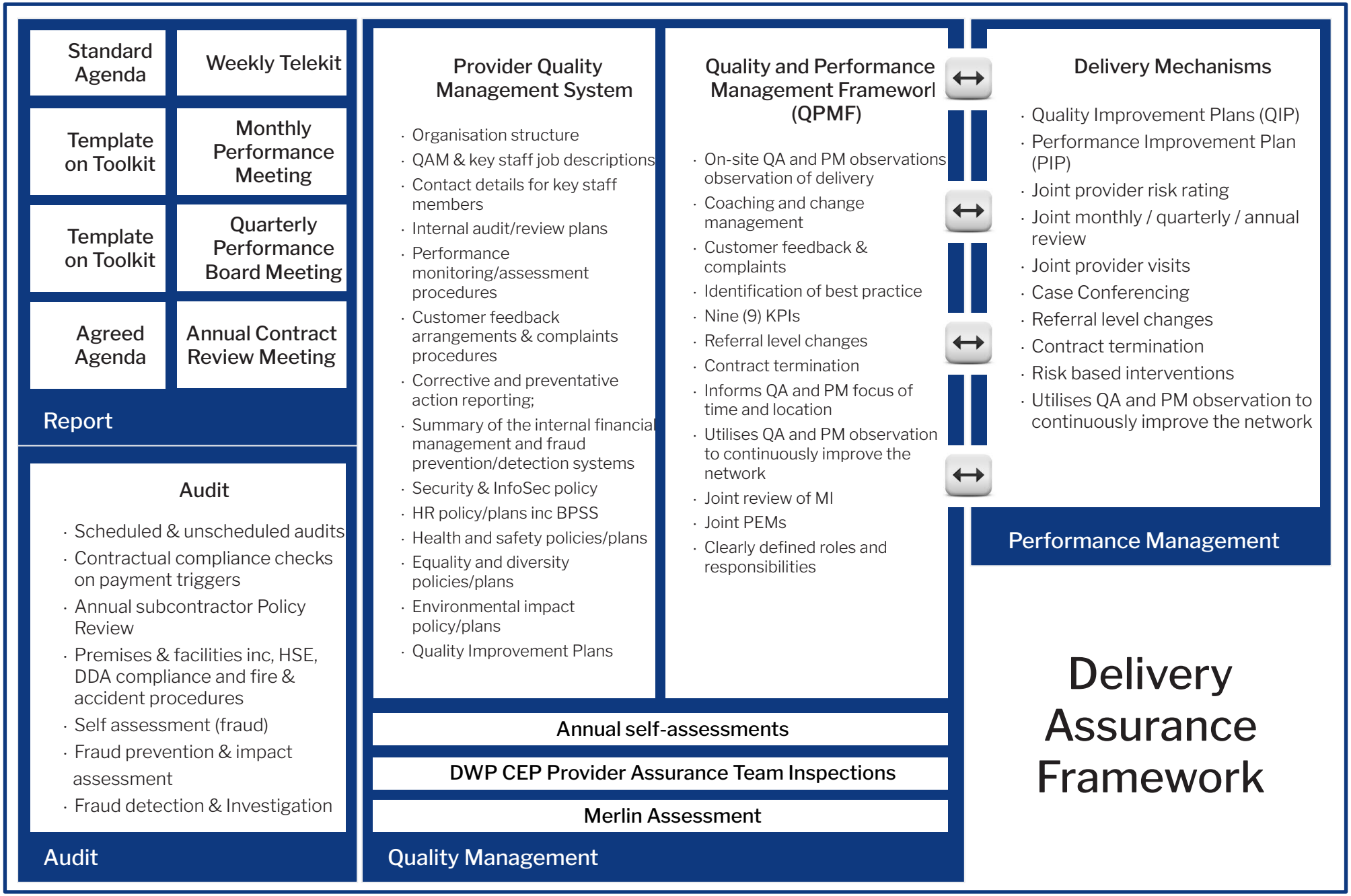
Performance management is the structured conversation about the things that matter

It is a cycle of:

It is reinforced through:

- Clarity
- Consistency
- Transparency/openness/competition
- Celebration
- Flexibility/change
- Commercial consideration

An example of a performance management system


Standard Agenda
Weekly Telekit
Template on Toolkit
Monthly Performance Meeting
Template on Toolkit
Quarterly Performance Board Meeting
Agreed Agenda
Annual Contract Review Meeting
Report
Audit
Scheduled & unscheduled audits
Contractual compliance checks on payment triggers
Annual subcontractor Policy Review
Premises & facilities inc, HSE, DDA compliance and fire & accident procedures
Self assessment (fraud)
Fraud prevention & impact assessment
Fraud detection & Investigation
Audit
Provider Quality Management System
Organisation structure
QAM & key staff job descriptions
Contact details for key staff members
Internal audit/review plans
Performance monitoring/assessment procedures
Customer feedback arrangements & complaints procedures
Corrective and preventative action reporting;
Summary of the internal financial management and fraud prevention/detection systems
Security & InfoSec policy
HR policy/plans inc BPSS
Health and safety policies/plans
Equality and diversity policies/plans
Environmental impact policy/plans
Quality Improvement Plans
Quality and Performance Management Framework (QPMF)
On-site QA and PM observations observation of delivery
Coaching and change management
Customer feedback & complaints
Identification of best practice
Nine (9) KPIs
Referral level changes
Contract termination
Informs QA and PM focus of time and location
Utilises QA and PM observation to continuously improve the network
Joint review of MI
Joint PEMs
Clearly defined roles and responsibilities
Annual self-assessments
DWP CEP Provider Assurance Team Inspections
Merlin Assessment
Quality Management
Delivery Mechanisms
Quality Improvement Plans (QIP)
Performance Improvement Plan (PIP)
Joint provider risk rating
Joint monthly / quarterly / annual review
Joint provider visits
Case Conferencing
Referral level changes
Contract termination
Risk based interventions
Utilises QA and PM observation to continuously improve the network
Performance Management
Delivery Assurance Framework

Standard reports

Monthly and Quarterly Performance Meetings

- ‘Attachments’ and ‘Starts’
- Job Outcomes
- Sustained Job Outcomes
- Percentage of customers not seen with the required frequency during each contracted period
- Contractual administration (e.g. caseload sizes, security concerns)
- Employer relationship management activities
- Quality and Compliance
- Successes from last month or quarter
- Challenges, and actions to address them
- Forecasts for next month or quarter

Weekly Telekits

- Review of actions from previous meeting
- High level Key Performance Indicators
- Underpinning Performance Drivers
- Performance Forecasts/Targets
- Communications and Toolkit news

KPI Summary

Engagement	1	**Programme Attachment**	Initial contact and PPEP commenced within 7 days
	2	**Welcome Session**	Welcome session within 14 days of referral
	3	**Provider Attachment**	3 meetings and a completed PPEP within 28 days
Service/ Ongoing Engagement	4	**Frequency of Contact**	Average of 2 face-to-face contacts per month
	5	**FTA Contact**	Customers who FTA contacted within 3 days
	6	**DMA**	FTAs eligible for sanction have case passed to JCP for DMA
Outcomes	7	**Referrals to Job Starts**	Job Starts measured against referrals
	8	**Job Starts to Job Outcomes**	Job Outcomes measured against Job Starts
	9	**Sustainment Outcomes**	Sustainment measured against Job Outcomes

Levels of performance and tools

For all KPIs, there are two levels of performance:

- Minimum Performance Level
  - Less than this is **Minor Performance Failure**
- Lower Performance Level
  - Less than this is **Major Performance Failure**

Depending on level of underperformance, different tools may be used:

- Quality Improvement Plans (QIP)
- Performance Improvement Plans (PIP)
- Change in service user referrals/flows
- Contract Termination

PERFORMANCE MANAGEMENT TOOLS

PERFORMANCE (Higher ↑ Lower)

Achieving/ Exceeding target

Quality Improvement Plan (QIP)

Minimum Performance Level

Minor Performance Failure

Performance Improvement Plan (PIP)

- **Change in Referrals**
  - QIP

* Three consecutive months of Minor Performance Failure will constitute a Major Performance Failure

Lower Performance Level

Major Performance Failure

- **Contract Termination**
  - PIP
- **Change in Referrals**
  - QIP

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HBGI
Healthy Brains Global Initiative

TOWARDS A NEW CONTRACTING MODEL FOR FULL SERVICE PARTNERSHIPS

A consultation and a set of recommendations:

Strengthening existing services, increasing impact and accountability, re-emphasizing recovery, piloting new parallel outcomes contracts (with an emphasis on *purpose*), building the market and investing in the workforce.

Conducted by the Healthy Brains Global Initiative for the Mental Health Services Oversight and Accountability Commission of California, December 2023

WITH THANKS TO

The Healthy Brains Global Initiative (HBGI) team are indebted to all the people in California who gave so much time to teach and advise us on Full Service Partnerships (FSPs). The significant and life-changing impact of these services is evident from the commitment and the passion that came through loudly in so many of these conversations. We would like to express our special thanks to:

- The Department of Health Care Services
- The Mental Health Services Oversight & Accountability Commission (MHSOAC), leadership, staff and commissioners
- California Health and Human Services Agency (CalHHS)
- California Council of Community Behavioral Health Agencies (CBHA)
- Cal Voices
- Local members of the National Alliance on Mental Illness
- Disability Rights CA
- The Steinberg Institute
- Tom Insel
- San Diego Regional Taskforce on Homelessness
- The Behavioral Health Directors and their teams in Nevada, Sacramento, San Francisco, San Diego, Orange, LA and Santa Barbara

The managers, staff and clients of:

- Stanford Sierra Youth & Families
- Victor Community Support Services
- Turning Point Community Programs
- Felton Institute
- Senaca Family of Agencies
- Telecare
- Pathways

CONTENTS

BACKGROUND

The history of Full Service Partnerships and the reason for this review

The HBGI review

Who are HBGI

THE HISTORY OF FULL SERVICE PARTNERSHIPS AND THE REASON FOR THIS REVIEW

In enacting Proposition 63, the Mental Health Services Act (MHSA), California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission (MHSOAC/Commission) with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care.

The Commission was designed to empower community members, with Commission membership representing consumers and their families, service providers, law enforcement, educators, and employers, as well as State officials. The Commission puts consumers and families at the center of decision-making, promotes community collaboration, cultural competency, and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

The MHSA prioritizes addressing several key negative outcomes often associated with unmet or under-met mental health needs. These include: reducing family separations, reducing criminal justice involvement and imprisonment, homelessness, unnecessary hospitalizations and unemployment, school failure and, most generally, prolonged suffering. The goals can be referred to as supporting ***people, place*** and ***purpose*** to achieve wellbeing[1].

For persons not yet experiencing the most severe negative consequences of mental illness, the goals are to prevent disease from emerging or progressing wherever possible, or to intervene early in disease emergence to avoid prolonged and serious consequences including family fracture, homelessness and unemployment. For those whose illnesses have already become severe and disabling, the goals are to work with those persons to design and implement strategies to enhance wellness, promote recovery and build resilience.

[1] See the Appendix on 'outcome domains'.

In furtherance of AB 34 (Steinberg) in 1999 and AB 2034 (Steinberg) in 2022, California's Full Service Partnership (FSP) programs are intended to be recovery-oriented comprehensive services, targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe, chronic mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve and maintain people in the community rather than to rely on state hospitals or other locked institutions to do so. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing holistic services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives.

The name – Full Service Partnership – reflects the collaborative relationship between the service provider and the service user or member, and when appropriate the service user's family – as defined by them, through which the provider plans for and provides the full spectrum of community services so that the service user can achieve their goals, through a 'whatever it takes' approach to meeting needs. By supporting recovery with individuals who otherwise would be caught in a cycle of hospitalizations and incarcerations, FSPs help people develop and advance toward personal mental health goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the MHSA and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

FSPs represent an estimated $1 billion annual investment in public funds and have tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs.

As of 2020, more than 60,000 individuals were enrolled in an FSP program, though the numbers currently fully engaged are unclear (with issues around tracking and reporting) and there are questions regarding service user selection and turnover. FSP programming also varies greatly from county to county, with different operational definitions, lack of consistent data processes, and variation in performance.

Several converging factors have prompted policy makers to raise concerns that California's MHSOAC investments in FSPs may not be adequate or that existing contracting and management of FSPs may not be optimal. This includes their ability to address:

- An increasing number of residents living unhoused, many with unmet mental health needs;
- Waiting lists to enter State hospitals for mental health care under felony Incompetent to Stand Trial designations;
- Ongoing reliance on local law enforcement and community hospital care as mental health consumers cycle in and out of mental health crises;
- The relationship between prison incarceration, mental health and homelessness.

THE HBGI REVIEW

In 2023, the MHSOAC contracted HBGI to undertake a review of the current FSP contracts.

HBGI were tasked with exploring the performance of FSPs, with a particular focus on contract design and performance management, and describing if and how outcomes-based contracts and/or enhanced performance management systems could improve that performance or otherwise strengthen wider behavioral health delivery. This is a qualitative review drawing on the experience of the HBGI team both in contracting and performance management, and in behavioral health in California.

From July to September 2023, HBGI engaged with policy makers and influencers in Sacramento. We spoke with and learned about FSP delivery from County leaders and their teams in six counties. We then did a 'deep dive' in three of these counties (Nevada, San Francisco and Orange), where we also visited service providers and spoke to service users and other stakeholders. We were joined by a service recipient/advocate (volunteer representative from CalVoices) to ensure we incorporated the lived experience perspective up front.

WHO ARE HBGI

The Healthy Brains Global Initiative (HBGI) was established in 2019 as a 501.c.3 not-for-profit, with the support of WHO, UNICEF, the World Bank and the Wellcome Trust, to address the global lack of understanding and services related to poor mental health - and its causes and consequences. We are using performance-based contracting to create a sea change in the scale and impact of mental health and related services - either contracting and funding directly ourselves or as a technical partner with governments. In all cases, we look to pay for results, not waste, and we generate rich 'live' data on service delivery and outcomes. HBGI is funded by philanthropy and through government contracts.

The HBGI team has a unique depth and breadth of experience in the contracting and performance-management of life-changing services for vulnerable communities. Our previous projects have ranged from leading employment services contracts (for people with multiple social, physical and mental barriers to work) reaching over one million people in a high-income country, to mobilizing performance-based basic and essential health services for 35 million people in a conflict affected low-income country. We have overseen eleven Social and Development Impact Bonds to date, including homelessness, school exclusion and refugee integration. We bring significant experience of leadership in behavioral services in California, as well as across rehabilitation services for veterans.

EXECUTIVE SUMMARY

Key Observations

Main Recommendations

In general, in undertaking this review, HBGI noted that there is variety between counties in the detail of the contracts and considerable variation in the cost per service recipient. In addition, we saw significant differences in the way FSPs are managed by counties and in the service capacity/capability of both contracted providers and County-staffed teams. Overall, however, FSPs across the State seem to have very similar objectives and, on the whole, make up a fairly homogeneous service. Of note, the level of contracting for FSP service provision (as opposed to services being delivered in-house) varies greatly between counties from almost none to almost all, such that any new contracting strategies will have a much larger impact on those counties that are heavily invested in community-based contracts.

During our engagement we were struck, above all, by the highly committed and professional workforce who deliver care to people with very complex histories and ongoing needs. We met inspiring County and contracted provider staff, including some amazing peers, going the extra mile on a daily basis for clients suffering from severe mental illnesses as well as addictions. In addition, we met service users who are remarkable people themselves, and their families, whose stories and hopes for the future were deeply moving.

However, we also observed the tensions currently prevalent in the service as a result of the drive for service provider 'productivity' in terms of the proportion of time they can claim as billable through MediCal. In the FSPs for adults, we saw an emphasis on treatment, with insufficient attention given to the progression of service users towards goals or outcomes (particularly around ***'purpose'***), despite the regulations requiring services to be client-driven and focused on recovery and resilience. In many (but not all) FSPs, the service providers are struggling to recruit and retain staff, and the system is therefore well below its contracted capacity. There is generally inadequate tracking, reporting and reviewing of performance and little to no visibility of which contracts are performing well or badly – which hinders continuous improvement.

We did not explore and have not reported on attempts to address substance use.

This Executive Summary sets out our key observations and main recommendations at a high level. The recommendations are described in detail in the following section.

The appendices to the Report provide the background to these recommendations, with our observations and challenges divided into three separate sections:

1. **Program Performance and Performance Management;**
2. **Supply and Demand, and;**
3. **Workforce.**

We then offer a framework of the 11 questions that high-performing contracts should answer, as well as a definition of the domains of ***People, Place*** and ***Purpose*** that we contend are the three corners of 'community' that a mental health program must address. We analyze the FSPs against this framework and set out the detail of a potential purpose-led outcomes contract.

Finally, we provide some thoughts on the Technical Assistance that will be needed for next steps, without adding to the burden on counties, in implementing any recommendations to strengthen FSP performance that State and counties choose to take forward.

KEY OBSERVATIONS

The themes that emerged during our review of the FSPs are as follows:

The FSPs deliver significant clinical impact and savings in reduced hospitalization and incarceration.	The Child FSPs help young people (and to an extent their families) deal with trauma and move on. The Adult FSPs save lives, stabilizing people with serious mental illness and wrapping care around them.
Targeting individual-level outcomes on the Adult FSPs would enhance program quality and impact.	Targeting positive, personal outcomes, as opposed to just focusing on high level clinical impact, would improve outcomes for individuals, be a more effective performance driver and in the end have a more profound population impact.
Across the domains of *People, Place and Purpose,* Adult FSPs need to strengthen their focus on *Purpose*.	In other words, the culture of these FSP services should be rebooted towards one where pursuing meaningful life goals with clients is primary, rather than relegating this as secondary to clinical goals. Such a reframe of focus can be achieved by changing what is measured/reported and by baking incentives for successfully fostering purpose in life into the funding of contracts.
The culture of the service needs a reboot.	It is not incentivized to do *'whatever it takes'* but *'whatever we can bill'*. The service has become homogeneous (whether full 'fidelity' or not to a particular model) and is losing its ability to respond to individual needs. It emphasizes treatment not recovery. It is a medical model emphasizing what is wrong with a person.
There is an urgent need to start reporting operational performance across the State on a regular basis.	This reporting would include a comparison of the performance between contracted providers and between in-house government versus contracted provision. Not doing so significantly decreases accountability and limits potential performance improvement (such as best practice sharing) both within and between very different geographies. At present, no County knows how any other County is performing and no one knows who the best providers are in each County or across the State.

There is a lack of systematic performance management (such as monthly performance reviews).	This is partly because of a lack of meaningful performance measures (including progression of service users towards their individual goals/outcomes). It is also due to a lack of performance management experience and tools in both providers and County teams. In small counties, it is also the lack of an adequate budget.
Attempts to use incentive-based payments with providers have not proven successful to date.	In counties that have been implementing incentive payments to drive performance, results have been unsatisfactory. This is in large part because they are not tied to meaningful, operational performance targets and the potential fiscal rewards are not large enough to garner attention.
The FSP system is running at about 70% of its capacity.	Though principally because of the difficulty recruiting and retaining staff, access to FSP services can be difficult, confusing, and often traumatic for service users and their families.

MAIN RECOMMENDATIONS

We recommend, in response, that the State and counties consider how to strengthen their FSPs and service offer, and gather learning in order to inform future FSP contract revisions, in two ways: firstly, through implementing several new performance-based pilot programs, and, secondly, through introducing new performance management and reporting standards. It is suggested that the same rigor in performance management could be applied, possibly as a subsequent step, across all levels of care.

The detail of the pilot programs should be designed in response to the specific context of each County and in consultation with all stakeholders. However, as a starting point, we draw on our experience in multiple country contexts as well as in California to describe 3 possible pilots:

1. A new, purpose-led outcomes contract to run in parallel with current FSPs. The service providers will be paid largely on the basis of the individual outcomes they deliver for service users in the domain of ***Purpose.*** The example we give here is a program targeting educational or professional training participation and sustained employment outcomes (i.e. helping service users find and keep jobs).

2. An extension to a current FSP contract to create a Follow-On program with lighter-touch support for service users ready to progress on from the intensity of an FSP, possibly emphasizing the use of peers for ongoing engagement and support. Service users will also be supported to draw up an Action Plan and select the outcomes they would like to achieve. This could be delivered by the FSP provider or in partnership with a Club House type program such as Fountain House.

3. A new, place-based outcomes contract.
    a. An outcomes contract aiming for the impact of a reduction in criminal recidivism rates. A 'through the gate' service to be delivered partly inside and partly outside of jails with the service provider paid for each person reconnecting outside, being accommodated, and achieving purpose (such as employment), as evidence of their re-entry into the community.
    b. An outcomes contract targeting a designated locality of homeless people, such as an 'encampment', i.e. where a group of homeless people have established themselves and formed a de facto community. This contract, to run in phases, would initially engage the community to learn what they want to achieve, then, move to a phase with the service provider paid to deliver the practical, measurable and verifiable outcomes selected by the community.

In our observations section below, we also address the potential for additional 'market stewardship', investing in building the capacity of providers and creating opportunities to share best practices. We further recommend the development of a State-wide workforce strategy, to address the huge pressures on staffing.

RECOMMENDATIONS

Performance-based contracts

Performance Management

The following recommendations are a starting point. They are a place holder, offered as a menu of possibilities for counties to consider and, in some scenarios, for the State to facilitate (e.g. by declaring that performance-based contracting is an approved use for unspent Innovation (INN) funding up front and by taking on the central funding of performance management capacity building). Any service enhancements to be taken forward by a County must be co-created with the full range of relevant stakeholders including service users, families and advocates, as well as key local and State administrators.

As the counties have different supply-demand challenges and will be looking for different improvements to FSPs (and their wider mental health system) in ways specific to their own jurisdiction, there will be different use cases from County to County. Along these lines, the smaller counties may look to partner with larger neighbors and co-commission services or purchase Technical Assistance to implement some of the specific performance management tools together. It would be time-consuming and costly to commission Technical Assistance on a County-by-County basis. A central contract, administered perhaps by CalMHSA, could be more efficient.

The recommendations below describe ways to enhance service offerings through ***performance-based contracts***[2] and improved ***performance management***.

[2] Further research and guidance on performance-linked contracting can be found in the publications of a number of organizations, including Brookings Institution, Oxford University's GOLab, Social Finance (UK and USA), UBS Optimus Foundation, and the social investor, Bridges Outcomes Partnerships.

PERFORMANCE-BASED CONTRACTS

As a place holder, we describe here three approaches to piloting performance-based contracts:

1. A new, purpose-led outcomes contract running alongside FSPs;
2. An amendment to FSP contracts to create a Follow-On program;
3. A new, place-based outcomes contracts (jail and/or 'encampment community').

The objective of these pilots are:

- To strengthen the service offer, widening service scope, bringing a greater emphasis on recovery, delivering more, high-quality outcomes for more service users;
- To help State, counties and providers learn more about performance-based contracting and facilitate a move from pilots to wider application;
- To provide an opportunity to understand better the needs of existing FSP service users as well as people pre-FSP and post-FSP;
- To test the ability of services to deliver if they move away from 'level of need' as the segmentation model.

These are suggestions based on the observations set out in this Report. They are all focused on adults. Counties may identify different opportunities specific to their context and population, which could be developed into outcomes contracts according to their specification. All the pilot durations suggested below are for face-to-face program delivery, with some additional time for tracking of outcomes and final evaluation at the end. Up to six months should also be allowed upfront for collaborative contract design (including agreement on the weighting of performance-linked payments), procurement and mobilization.

Given all the changes currently impacting FSP contracts, it is not proposed that changes are made to them mid-stream. However, counties with FSPs to be retendered in the summer of 2024 might consider how elements of the recommended pilots below could be used to amend or form new contracts (possibly with a hybrid model that pays the provider partly on the basis of billing 'productivity' and partly linked to outcomes).

1. A PARALLEL PURPOSE-LED OUTCOMES CONTRACT

The simplest, and possibly strongest, model to pilot would be an employment outcomes program. Following a mobilization period of three to six months, this pilot will run for two years, with a further six months following the end of face-to-face delivery, when employment outcomes can continue to be tracked (and paid).

- Emphasizing the two outcomes of ***employment starts*** and ***employment being sustained;***
- With three *interim payments* to the service provider for developing an Action Plan with each person (including a short and long-term job goal), and for optional participation in formal training and supported employment;
- With two *outcomes payments* to the provider, one for each person starting a job and the second for each person who sustains that employment for at least three months[3];
- With 65% of the payments attached to these two outcomes (split 50/50 between them);
- The training and supported employment payments can be 'rolled up' and paid on top of the job start if the person moves straight to work.

The employment must be in a 'good job', which will be defined in advance and meet minimum criteria in order to qualify – ideally 'competitive employment' in the open labor market. Key features will include things like hours of work, salary level, health and safety, and travel to work time. It may mean helping someone working in the 'grey economy' to formalize that work.

As far as the relationship between this program and the existing FSPs in the area goes:

- The FSP can refer someone into the employment program, and that individual can participate in both at the same time;
- The employment program can also recruit direct from outside FSPs as long as the individual meets pre-determined criteria, to be agreed (such as a diagnosed mental illness and/or addiction).

Appendix V sets out further detail on such a contract.

2. AN EXTENSION TO AN FSP CONTRACT TO CREATE AN FSP FOLLOW-ON

To address the concerns about Adult FSPs holding on to service users and blocking the program so others cannot be referred, counties could pilot the extension of an FSP, with an add-on Follow-On contract, i.e. for service users who no longer require the full intensity of an FSP but do need ongoing support. This could test the value for service users of moving on, establish the cost of such lighter-touch support, and cost-effectively create additional capacity in the FSP.

The Follow-On can be delivered by the existing FSP provider extending their service/team or in partnership with another organization.

Under this model:

- The FSP service providers will be paid an incentive for each service user progressing, with an agreed Action Plan, to their FSP Follow-On;
- The Follow-On includes a lighter touch of engagement, with larger caseloads, possibly with an emphasis on peer support;

[3] Evidence from elsewhere suggests that once the individual has reached three months, their chances of continuing are high.

- In drawing up the Action Plan, the service user will agree two desired outcomes in each of the domains of People, Place and Purpose (they will select these six outcomes from a list of measurable, verifiable outcomes in each domain drawn up during contract design);
- The service provider will be paid with a mix of budget reimbursement and additional payments for when each service user achieves the outcomes that they selected across the three domains;
- The service user will have an opportunity to overperform against base targets for the outcomes and earn up to 30% extra as a result;
- There will be monthly reporting on service user contact and outcomes achieved;
- The Follow-On could be subcontracted to or delivered in partnership with another provider, such as a Club House;
- The service user can select to return to the full FSP at any time (though may need to wait until a place becomes available).

Following mobilization, the pilot will run for two years, at which point the contracting body, the service provider and the service users must consider if and how ongoing support remains.

3. PLACE-BASED OUTCOMES CONTRACTS

Rather than targeting populations on the basis of individual characteristics, such as a mental health condition or a personal history of hospitalization, it is possible to target services by *place*. Poverty or social exclusion tend to be highly centered in certain locations/communities. Targeting services by place potentially escapes the artificial segmentation by 'level of need', which simply does not reflect the nature of exclusion or mental illness. It enables, if focused on outcomes, a more personalized response, with less prescription upfront of how each individual's need is expressed. It can embrace the nature, culture and role of community.

Piloting services by place is also an opportunity for focused collaboration between different system players. In particular, it could be used to reinforce collaborative working with Justice (notably the jails) and Homelessness, possibly as co-contractors. It will additionally provide further insights into eligibility for FSPs in both these populations.

a. In the case of jails, the recommendation is to contract a service provider who will:

- Deploy a team to be based partly in the jail and partly on the 'outside';
- Deliver an enhanced 'through the gate' service;
- Have payments attached to three key outcomes, with outcomes (as above) agreed with the service user from preselected options, with an emphasis on reconnecting, accommodating and finding purpose (ideally employment);
- As above, be able to earn extra from overperforming against base targets;
- Have monthly reporting (and reviewing) of service activity (i.e. number of people actively engaged) and the outcomes measures;
- Track the impact on reoffending on an ongoing basis.

The eligible population will be everyone spending time in the jail(s). A mental health assessment will be undertaken by the service provider (if there is no existing, recent diagnosis) to inform impact evaluation.

Following mobilization, the pilot will run for a minimum of two, ideally three years (with a period of tracking beyond that). This pilot is an excellent opportunity to attract new service providers, though that will require a big enough and long enough contract. There are providers demonstrating high performance in this space who are not currently delivering FSPs in California. There is a good evidence base on what can be delivered at what cost.

b. In the case of homelessness, the evidence base is weaker and it will be harder to price outcomes payments at the outset. Therefore, a staged move to outcomes payments is proposed. The recommendation is to contract a service provider to:

- Be accountable for achieving outcomes with a designated homeless community, such as an encampment (c.50 to 100 people per contract);
- Deploy intensive/assertive case management into the community, to be paid for the first six months entirely on a budget reimbursement model;
- Agree with the community how they would like to express outcomes across the three domains of ***People, Place*** and ***Purpose*** (within certain criteria, i.e. they must be relevant, measurable and verifiable);
- Start delivering outcomes;
- Agree, six months in, the 'rate card' with the County, i.e. what outcomes are being paid for and how much for each one;
- Receive, from six months on, outcomes payments to cover 50% of the previous budget reimbursement, with an opportunity for the service provider to overperform against baseline targets by 30%;
- Deliver for a further 12 months and then review the outcomes, the targets and the payments once more, and potentially revise again;
- Complete delivery two and a half years after first community contact (plus six to 12 months of tracking beyond).

A NOTE ON THE WEIGHTING/PERCENTAGE OF PAYMENTS LINKED TO PERFORMANCE

There are no definitive guides to how to weight payments to incentivize performance.

First of all, it is important to have clear deliverables which emphasize outcomes. Having strong performance management in place to track, record, report and review progress against these can be the greatest driver of performance.

This can be strengthened by connecting payments to delivery. Where exactly along the 'results chain' (of inputs, outputs, outcomes and impact) these payments are attached and their relative weighting will depend on a number of factors, including: the time taken between each step along that chain; the cost of each step; the evidence of attribution between them; the maturity of the service provider market, and; the scale and duration of the contracts.

It is important for the contracting body and the service provider both to build a fully-costed model of potential performance. This enables them to price it accurately and to understand the implications of any outcomes-based payments for cashflow.

On the whole, attaching payments to impacts may be too far from delivery to act as a performance driver – and too costly in terms of upfront working capital requirements. The closer they are connected to outcomes the better, as long as these are practically measurable and verifiable.

They must be large enough as a percentage of the total contract to get the attention of the service provider. If they are too small – as in the current incentive contracts being used for FSPs in some counties, in a range of 2 to 6% – then the service provider will simply look to spend up to the core funding and any incentive will simply be a 'nice to have'. The authors of this report have seen 20% attached to performance (typical in World Bank training programs) also fail to shift behavior and service culture. It is important to note that in all these instances there has also been inadequate performance management to mitigate this.

The Human Resources Agency in New York contracted a variety of employment programs with between 70 to 100% linked to outcomes[4]. The Employment Zones in the UK, based on USA pay-for-performance programs, had around 80% tied to job starts and sustained employment[5].

See Appendix II for more on the characteristics of high-performing contracts.

[4] Armstrong D., Byrne Y., Patton L. and Horack S. (2009) *Welfare to work in the United States: New York's experience of the prime provider model,* Research Report No. 614, Department of Work and Pensions, London.

Desai S., Garabedian L. and Snyder K. (2012) *Performance-Based Contracts in New York City: Lessons Learned from Welfare-to-Work,* Rockefeller Institute Brief, State University of New York

[5] Griffiths, R. and Durkin, S. (2007) *Synthesising the evidence on Employment Zones,* London: Research Report No 449, Department for Work and Pensions.

PERFORMANCE MANAGEMENT

In addition to the contract pilots detailed above, it is recommended that counties (and State) consider developing and requiring new standards in:

1. Performance reporting;
2. Performance management.

1. PERFORMANCE REPORTING

There is an opportunity to enhance significantly FSP performance through implementing new performance reporting standards. This will deploy a powerful driver of performance. It will increase (and be seen to increase) accountability (at every level) and will facilitate the sharing of best practice. It will provide additional incentive to innovate and encourage a flourishing and vibrant market of service providers.

It is recommended that each County publishes monthly (within a fortnight of the end of the previous month), a dashboard comparing the performance of all FSP providers in that County (by age group/type of FSP), reporting:

- Total number on the program (and as a % of contract total 'slots');
- Number of new starts in the month;
- Number of people progressing positively on in the month;
- Number of people lost from the program (e.g. returning to prison or disappearing or moving away) in the month;
- Total cost of delivery that month (and as a % of contracted monthly cost);
- Percentage of caseload seen once in-person in the month;
- Percentage of caseload seen twice or more in-person in the month (for more than 30 minutes each time);
- Number of people moving off the street and into accommodation;
- Percentage of people in supported accommodation;
- Percentage of people in independent accommodation (including with family);
- Percentage of people engaged in a 'meaningful activity' (according to a clear definition);
- Number of people securing a 'purposeful outcome' (e.g. starting school, training, volunteering or employment, as selected by the service user) in the month;
- Case manager caseload sizes.

In order to do this, of course, the service providers will have to submit a monthly report for each contract. This can be a basic Excel file.

Twice a year, the State should publish a consolidated view, reporting the performance of the top and the bottom 20 contracts in each category, the average across the State, and the performance of the top 20 providers in terms of financial contract value.

On an annual basis, a service-user satisfaction score, based on a survey, can be added to the consolidated view.

2. PERFORMANCE MANAGEMENT

Alongside the implementation of new reporting standards, there is an opportunity to improve the performance management at State, County and service provider level. It is recommended that at a County and service provider level this includes:

- Agreed *operational* performance measures (and targets) with service providers that are relevant to the contract and context (e.g. the MediCal billing), and that also encompass the measures recommended in the new monthly reports;
- New monthly Performance Packs, which report these performance measures, in-month, cumulatively and trending over time. This reporting should take a whole contract view, as well as tracking activity and ***progress*** by individual and by cohort (e.g. everyone who started in a particular quarter);
- 'Exception reports' to highlight anyone not being contacted or not progressing as desired;
- A Performance Board to meet on a monthly basis to review performance, to which the service provider's local program manager presents the Performance Pack and their report, with membership possibly to include County contract manager or monitor, and other stakeholders (such as a service user, peer or NAMI representative);
- The review and amendment of contracts, as necessary to add/improve 'step in rights' to be implemented in the event of under-performance.

A small County with limited bandwidth might require monthly reporting from the service provider and copies of minutes/actions arising from their monthly Performance Board, then attend the Board in person on a quarterly basis.

Investing in the development of the service providers, alongside strengthened performance management, the State and the counties should consider their role as 'market stewards', as described above. This should include:

- Organizing periodic events (every six months in the counties and annually across the State) to bring together service providers. Collectively to review performance and share lessons;
- Developing a strategic workforce plan.

Further detail on this 'stewardship' role and on suggestions to address the workforce problem is set out in the first appendix below.

APPENDIX I:
OBSERVATIONS AND CHALLENGES

Here follows the observations and challenges on the basis of which these recommendations were made. They are divided into the following sections:

1. *Program performance and performance management;*
2. *Supply and demand;*
3. *Workforce/staffing.*

PROGRAM PERFORMANCE AND PERFORMANCE MANAGEMENT

Our key takeaways regarding performance and performance management are that the FSPs deliver vital, life-saving interventions which create a significant saving in the costs of hospitalization and incarceration. However, the current definition of success is limiting. There is an emphasis on treatment over recovery. The notion of 'Purpose' is largely missing from Adult FSPs and the voice of the service user is being lost. Services are generally homogeneous with little flexibility or personalization. This is not just exacerbated, but largely driven, by the focus on MediCal billing (however necessary this might be). The lack of any transparent performance reporting, including a comparison of all contracts/providers within each County and across the State, is limiting performance in a number of ways. There is an opportunity to invest in and grow the provider market.

In relation to the performance and performance management of the FSPs, we offer the following ***observations,*** with further detail on all of these following.

On the objectives and performance of FSPs:

- The success of FSPs (notably Adult FSPs) is defined generally as a reduction in homelessness, hospitalization and incarceration;
- FSPs appear successful in delivering this (and in delivering a cost saving as a result);
- Day-to-day performance measures focus on total caseload size ('slots'), number of staff, and 'productivity' in terms of number of minutes billable through MediCal;
- The service is in a period of transition, with a focus on billing and new documentation and, in some places, new IT.

On contracts, payments and assurance:

- Contracts to service providers include 13 pages of detailed 'look up tables' on all the activities that can be billed;
- Payments to providers are not linked to performance, though some small incentive payments have been piloted;
- The cost of FSPs varies greatly between counties (as does the percentage of the total MHSA budget allocated and disbursed);
- Caseload sizes are small and there is a high level of 'supervision' within each contract.

On performance reporting and performance management:

- Reporting on FSP performance varies greatly, as does program monitoring, though there is little proactive performance management;
- Small counties have very limited resources to manage contracts.

On service content – standardization versus personalization:

- On the whole, this is a homogenous service with little flexibility;
- On Child/Youth FSPs, the service users move on after 12 to 18 months, whereas on Adult FSPs they may remain for many years;
- The role of families changes, as far as the FSPs are concerned, as the service user becomes an adult;
- Some Adult FSPs have started to include an employment advisor in the team, though without any performance targets;
- FSP contracts and providers range in size, with some very small, local providers used to strengthen community engagement.

On housing:

- Finding affordable, available housing is a challenge everywhere.

It must also be noted:

- One of the biggest constraints on performance is the difficulty in recruiting and retaining staff.

Alongside these observations, we offer the following ***challenges and possible responses.***

On FSP performance – stability or independence, standardization or flexibility:

- Defining success in these terms (a reduction in homelessness, hospitalization and incarceration) is too simple and de-emphasizes consideration of service user wellbeing;
- These are not actually 'outcomes' but 'impacts';
- The prevalent service culture is the 'medical model', identifying what's wrong with people;
- Service users (on the Adult FSPs in particular) are not moved towards wellbeing and independence and connectedness;
- The notion of 'Purpose' as an outcome to pursue with clients receiving FSP is missing from the program and its accountability/audits;
- There is limited lighter touch support available for a service user to move on to after an FSP;
- Objectives/outcomes are defined and imposed top-down, not by service users (or families or communities);
- Calling the number of billable minutes 'productivity' is a misleading misnomer;
- Targeting on billable minutes creates a tension at the center of these services;
- 'Flex funds' are available in many places (to pay for incidental things like clothes) but these are tightly controlled by the counties;
- Services with rigid caseloads and targets for billing struggle to be flexible in line with service user need.

On performance tracking and reporting:

- Legislators and the general public do not know anything about FSPs and their impact;
- There is no comparative performance reporting and this is a major limitation;
- Comparing performance is still possible across different services and geographies;
- Reporting performance drives higher performance;
- Without reporting comparative performance, it is impossible to identify and learn from best practice.

On quality assurance:

- The layers of 'supervision' in services provide some assurance of quality but it is not always systematic;
- This ad hoc quality assurance may not mitigate the perverse incentives of targeting billable minutes;
- When counties report on FSP performance, it is often disconnected from operations and there is a weak feedback loop.

On IT systems:

- Most providers are double or triple keying into different IT systems;
- Most of the IT systems do not facilitate better case management;
- The transition to a new IT system in half of the counties has some teething issues.

On introducing outcomes contracts:

- The small incentive payments trialed in some counties have not worked;
- It may not be the right time to revisit existing FSP contracts and change the terms;
- Piloting some outcomes contracts in parallel with FSPs could strengthen service provision and build capacity in the system for a future shift more widely to outcomes payments.

On building provider capacity and the market:

- The State and the counties have an important role to play as 'market stewards';
- There must be comparative performance reporting (at every level) across the State;
- The homogeneity of providers limits learning;
- There are a number of things that can be done to make the market more attractive and to attract new players;
- Using very small providers has advantages but it may be advisable to use a 'prime contractor' (with an outcomes contract) to manage this.

These observations and challenges/possible responses are set out in detail below.

OBSERVATIONS IN DETAIL

FSP OBJECTIVES AND PERFORMANCE

There is generally agreement across all parts of the system that the objectives of the FSPs are to move people into accommodation, reduce hospitalizations and reduce incarcerations.

These are described as the 'outcomes' that the FSPs are seeking to deliver. Counties typically report periodically on their achievement of these – at a high level – such as comparing the number of days of incarceration of a cohort in the 12 months prior to and after starting on the FSP.

Performance across these three measures appears high, at least for the providers and counties that we met.

The State would like to verify this by matching the reporting by the providers with databases in justice and in health, but this is proving problematic.

The principal performance measures used by most counties and providers on a day-to-day basis are:

- The total number of service users registered with a provider;
- The total number of staff employed, in all the various positions, and their caseload sizes;
- So-called 'productivity', by which they mean the amount of time (measured in terms of minutes) that the service (and each member of staff) is able to claim as Medi-Cal dollars.

In some counties, providers are given additional objectives, which might include things like the time taken to start a new referral and producing/maintaining the necessary documentation. Counties vary between having objectives mainly around processes and those who have more aggregate measures.

The level of documentation required has increased with current changes to the system, and some counties have reduced the number of additional objectives in an attempt to mitigate this. This has included no longer requiring providers to report on service user engagement in meaningful activities.

There have also been changes regarding what is admissible or inadmissible as billable activity, with the removal of travel and administration time. The impact of this on the finances of the FSPs is yet to be understood. It is likely to have a particularly big impact in rural areas given the greater distances travelled to visit service users.

CONTRACTS, PAYMENTS AND ASSURANCE

This view of performance is generally reflected in contract design.

The contracts issued to the service providers are, on the whole, highly complex, including up to 13 pages of 'look up tables' describing the billable activities and their codes.

Payments to service providers are not currently linked to performance but some counties have been trialing the use of incentive payments to providers.

These have either offered an additional payment of between 2% and 10% over and above the contract value, or a similar percentage has been deducted from the contract value to be earned back if certain criteria are met. The criteria in most cases have been largely process-or compliance-oriented, such as time taken from referral to program start, level of interaction with service users and maintenance of the required documentation. In one County, the provider can earn an additional $1,500 for each person they step down from the program. In the majority of cases, the providers have failed to meet all the required criteria and no incentive payments have been made.

There is considerable variation in the cost of FSPs between counties.

Per service user, the cost is $17,000 in one County and $30,000 in another, and the range may actually be wider across all counties. This is said to be because of variations in wages and housing costs. To state it in such terms is indicative of the way the program is viewed as standard across all users. This is the allocated cost per person per annum on the provider's total contracted caseload. It is not possible to suggest any correlation or otherwise between cost and performance because of the lack of data.

Caseload sizes are generally small, starting as low as 10 per Case Manager on some programs.

These are contractually defined, so if there is insufficient staffing, the provider cannot take on referrals and the overall capacity of the FSP is reduced (though in some cases waivers have been issued allowing for small increases).

There are layers of supervision within each service which appear to provide strong, if not always very structured, quality assurance.

Service providers will have, for example: weekly supervisions of a Case Manager with a Team Leader; monthly peer reviews between Case Managers; monthly reviews with a supervisor sampling 20% of cases, and; a quality team reviewing case notes. Though the emphasis of the latter is likely to be on compliance with MediCal requirements, i.e. whether the records will be acceptable for billing.

PERFORMANCE REPORTING AND PERFORMANCE MANAGEMENT

The reporting on performance varies between counties in frequency and detail, and in who completes the report and what happens to it.

In some cases, an annual report is produced by a business office unit, entirely separate from the County's FSP contract management team. This report is comprehensive, based on data taken from the IT system(s) and also self-reported by providers, though it is again at a high level with simple summary scores. This report is not used in the ongoing performance management of service providers but will be referred to when new contracts are tendered. COVID had an impact on reporting, with some performance measures being removed because they were no longer relevant or practical.

In one County we visited, there is a monthly performance review with all providers, undertaken by a Monitor from the behavioral health team.

This is a large County, with the resources to manage this. Each month, they review individual cases. They also look at the 'outcomes' data of incarceration and hospitalization, and try to understand any variance or trends. They undertake regular service user satisfaction surveys. This County appears to have high FSP performance and falling rates of homelessness as well.

This level of engagement and active performance management appears to be the exception rather than standard practice, partly driven by the allocation of funds to counties.

In some smaller counties it is simply not possible because the County Contract Managers are responsible for huge numbers of FSPs along with other contracts. A small County, co-located with their single Adult FSP, almost share day-to-day caseload management and are able to rely on a trust-based relationship, but are stretched too thin for systematic performance management. It is not clear the extent to which the allocation of funds to counties is informed by an operating model that takes into consideration spans of control and the value of proactive performance management.

SERVICE CONTENT – STANDARDIZATION VERSUS PERSONALIZATION

There is some (but relatively little) variation in the flexibility that providers have to implement their FSP.

There is also a State-driven move towards full fidelity Assertive Community Treatment (ACT) or near-fidelity. On the whole, the different FSPs visited appear to be a rather homogenous service, with some variance in use of peers and client recovery funds or 'flex funds' (such as for clothes or to assist with housing) and additional resources available (such as supported accommodation options). There is no data comparing the use of 'flex funds' across providers and its link to outcomes.

The lack of variation and flexibility is a consequence of:

- A push towards common professional standards, in service content and in service staffing;
- A focus on process (exacerbated by the MediCal billing) away from the person and outcomes that matter to each individual;
- An emphasis, in line with the focus on process, on contract compliance as opposed to performance management of outcomes;
- A lack of meaningful data and of transparent reporting (including open comparison of providers), which drives policy makers/contractors at State level to revert to standardization for the sense of control it gives them.

The nature and content of Child FSPs and Adult FSPs[6] is clearly very different.

This is reflected in part by the difference in the average duration of time that a service user participates. A child will typically attend for between 12 and 18 months. An adult, on the other hand, may be on an FSP for many years. The next step for children beyond the FSP may be clearer, with more options existing in the system.

Families are an integral part of a Child FSP but the same families may feel excluded by an Adult FSP.

The family is an essential part of the solution for a child. Therapy may be needed by the whole family. The Child FSP looks to understand and address the role of the family relationship. In contrast, on an Adult FSP, the adult service user must obviously control access and information. The FSPs have to manage this carefully, but still need to engage with the community around the service user. Re-building family relationships may actually be an important outcome (that may be neglected).

[6] There are a wide range of different FSPs in addition to Child and Adult, varying by County, but including, Older Adult, Forensic or Criminal Adult, and Transition from Youth to Adult.

Some providers have deployed an Employment Advisor to sit within the team of Case Managers.	The Individual Placement and Support (IPS) model has proved highly effective in other places in enabling service users to maintain or to access employment. The staff in this role on the FSPs do not have outcomes targets and there are no outcomes payments to the service providers for employment. There is no data available on whether the model is working.
Some counties have purposefully contracted with small, local service providers, alongside some of the larger pan-State providers.	They have done this in an attempt to increase localization and diversity, as well as to encourage services that reflect the population being served (such as in its ethnicity).

HOUSING

The shortage of affordable housing is a challenge in all areas, with counties using 'housing dollars' to address this, with varying success.	It is managed differently in different counties, with some allocating a housing budget to providers from MHSA funds. This allocation is enough in some areas and inadequate in others. There has been no comparison made across counties to identify and share best practice. We did not come across any rent guarantee or landlord insurance schemes, which have proved effective in other countries.
Most of the providers and counties reported that their single biggest limit on performance was difficulty in recruiting staff.	This is addressed below in the section on workforce.

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

FSP PERFORMANCE – STABILITY OR INDEPENDENCE, STANDARDIZATION OR FLEXIBILITY	
The definition of performance or success as reduced homelessness, hospitalization and incarceration is an over-simplified measure.	It does not provide any insights into what it is that the FSPs deliver that actually improve an individual's wellbeing. It may be that simply providing accommodation and supporting/monitoring the taking of medication are sufficient to achieve these impacts. Defining success in this way pays no attention to the individual service user experience.
The stated 'outcomes' of reduced incarceration etc. are actually 'impacts' rather than 'outcomes', and this weakens performance management.	There are considerable cost savings (direct to the County purse) and positive social impacts from reducing justice involvement and incarceration. However, whilst it is important to measure these impacts and to understand the fiscal return, focusing the service on them does not reinforce, and potentially de-emphasizes, the experience/journey of each individual service user. Rather than tracking and reporting on each individual's experience, and reinforcing accountability for this, current reporting steps back to take a more global view. However, if each individual achieved goals around stability and independence (and this was tracked and reported), then the three big impacts would be achieved as a consequence.
On the whole, the culture of the service is derived from the 'medical model' that shapes it.	I.e. with the ***deficits*** of service users carefully assessed in order to determine, first, their eligibility and, then, their treatment. With success measured in terms of a reduction in negative outcomes, it is hard for the service to think about the positive ***addition*** of things to someone's life. One provider talked about identifying and addressing "functional impairments". The Adult FSPs in particular are all about treatment and not about recovery. There is no room for an asset-based approach, which would focus on each individual's assets (i.e. strengths and potential), help them to define goals and work towards them, and target actual achievement as outcomes.
The definition of success in terms of (just) these three impacts limit the service scope, so that service users are not moved towards wellbeing/independence.	The fact that once an adult has joined an FSP, they may still be participating many years later, is possibly indicative of the nature of that individual's mental and social condition and their level of need. It is also a reflection of the function currently fulfilled by these Adult FSPs, i.e. maintaining service users in a state of stability, without seeking progression. This is partly addressed in some areas by Wrap Around FSPs, though these are still about maintenance as opposed to recovery onwards.

There is limited long-term goal setting with service users on adult FSPs, and 'purpose' is missing from the service mix.	In addressing service user needs in terms of 'people, place and purpose' the FSP itself may fulfil the need for *people,* with staff and other service users becoming the kin. Most FSPs address the immediate need for *place,* with the majority of service users supported to secure accommodation in some way, and with the FSP premises offering a safe base; but there is little or, at best, an inadequate focus on *purpose,* with no emphasis on service users defining and achieving a personal mission (such as a job).
Once an individual is stabilized, a lighter touch level of ongoing support/maintenance might be sufficient, but no such provision is available.	With no follow-on provision in place, the FSP holds onto the individual. The position of FSPs within the system, and questions regarding the balance of supply and demand are considered below in the next section.
The outcomes that the program is targeted to achieve are defined and imposed top-down, with little or no consultation with service providers, service users, families or communities.	It is part and parcel of the service culture, but if we were working towards independence, then the service user should be given agency over the process. This may well mean challenging the received wisdom of the service, which views the service user as 'in need' and requiring the control of the professional 'expert'. It would also mean challenging the learned helplessness of a person who has had to sink through multiple layers of 'help' before arriving at the FSP in the first place.
High 'productivity' on an FSP should surely be defined as the achievement of as many meaningful outcomes as possible for as many people as possible.	The claims for billable minutes would be better called 'financial drawdown' or simply 'income'. It is essential to maintain the financial viability of the program, but it must be balanced against the desired service culture.
The need to capture the activities which will draw down MediCal money creates a real tension in the heart of the service.	The provider, and in many places the Case Manager, is managed against their ability to claim these dollars. They are given targets that they have to achieve. Towards the end of the week or the month, there is an incentive to engage the service user in something that is billable, even if it is not exactly what they need. To date, there has been no push to reduce the time spent travelling, for example, by reducing the number of home visits. But this may change as the actual financial picture emerges.

	Anecdotally, on programs (such as some Assisted Outpatient Treatment), where there was no requirement to capture billable activities, the outcomes were very strong. This included reductions in hospitalization and incarceration. It also delivered the more immediate, individual outcomes such as people being reunited with families and moving back home. Service providers want to have this flexibility and do 'whatever it takes' but the behavior of a contracted provider will/must follow the contract.
Where 'flex funds' are available, the counties generally exert a high level of control over all expenditure.	The FSP provider must, typically, secure approval each time they want to spend over $1,000 for adults and maybe $500 for children. This level of control reflects the nature of the contracting, and the contractual relationship, and the fact they are basically still managed as budget-reimbursement. It weakens the accountability of the service providers and their ability to genuinely flex the service around the needs of the individual.
Contractually setting caseload sizes may provide a level of quality assurance but constrains service delivery.	With fixed caseload sizes and targets for billable minutes, the service providers are forced into a particular level of contact per service user. This limits their flexibility to increase or decrease this in line with service user need.

PERFORMANCE TRACKING AND REPORTING

To ensure continuing funding for FSPs, the story has to be told.	Legislators and voters have little or no visibility of what the FSPs deliver, quantitatively and qualitatively. The data that service providers collect and report to the State is limited, and it is not used for anything. It is important to get behind the population-level percentages that are currently reported (e.g. in terms of reduced hospitalization), which fail to bring the service alive. Some counties collect the powerful case studies of the lives that the FSP saves, but these are not always communicated widely.
There is no comparison made, at least publicly, of the performance of different providers, which significantly hinders the performance of FSPs everywhere.	Most providers and County staff cannot identify/name who are the best or worst performers, either in their County or across the State. Even within some providers who deliver across multiple counties, they do not report this and can only anecdotally identify the best/worst performing contracts.
Reporting the performance of all contracts/providers is still relevant and important even with significant differences in local contexts.	Within their age bands, the FSP contracts target the same groups. They share the same overall objectives (though these should be refined). Without transparent reporting of data, there is no true accountability in the system – to the taxpayers, to the communities or to the service users.
Reporting and comparing performance across providers drives higher performance.	It is a powerful motivator. It identifies failing providers, who can be supported to improve or, ultimately, removed from the system. It rewards the providers who perform exceptionally.
Without collecting the data on what works, it is impossible to replicate success across the system.	If all that providers are required/incentivized to do is to record billable activities, it significantly limits any potential learning and inhibits any search for continuous improvement. One of the reasons that one County has ceased requiring providers to report on meaningful activity, is because the providers failed to fill in the forms capturing this activity. There is insufficient incentive for frontline staff to report on this, given all the other things they must report – which are generally linked to so-called 'productivity' and payments.

QUALITY ASSURANCE

The layers of supervision within the service provide a degree of assurance that the level of care is appropriate, but this is not applied systematically.	Counties, in the first instance, should assure the providers' internal quality assurance systems and, then, based on any risks identified in that, undertake direct assurance of the services themselves.
The ad hoc quality assurance (QA) that is typically undertaken may be insufficient to mitigate the perverse incentives driven by the billing culture.	This relates to the QA undertaken by providers, as well as the monitoring undertaken by the County. In both cases, there is a lack of systematic tracking and reviewing of all individual progress, with, for example, 'exception reports' highlighting service users who have not been engaged within the last month.
Counties periodically, typically, undertake and report an analysis of FSP data, but this is in isolation of delivery.	It is a remote evaluation exercise. The analysis is not used in performance reviews with the providers. It is not used to drive continuous improvement.

IT SYSTEMS

Most providers are, at least, double-keying, i.e. entering data into at least two different systems.	Many are actually entering data into three systems, and will often employ teams of administrators to do so. This is going to impact on cost-efficiency, data quality and staff motivation.
There is a lack of consistency in the functionality of the IT systems used by service providers.	Some providers (a small number) have systems which assist staff with case management, such as highlighting service users who are due appointments or who are behind on their medication.
The transition to a new data/case management system, adopted by nearly half of the counties, has not been entirely smooth.	Reporting functionality was not immediately available to track provider spend and Medi-Cal 'productivity'.

INTRODUCING OUTCOMES CONTRACTS

The incentive-based payments trialed by some counties have not been utilized/spent and have failed to change service provider behavior in a positive way.

In one County, only around 10% of the allocated funds have actually been paid out.

Some of the FSP contracts are to be renewed at the end of the current year and there is an opportunity to revisit their terms, but most are mid-cycle and perhaps there is already enough change in the FSP world.

It would be possible to introduce a payment model in which a proportion (c.50%) of the payments are tied to billable activities (to ensure the County is able to bring in the funds), and the remainder is linked to a mix of impact (i.e. reduced hospitalization and incarceration) and individual outcomes defined with/by service users.

Pilot outcomes programs, contracted in parallel with the existing FSPs, could provide the learning to inform the next evolution of FSPs, as well as for the wider system.

Piloting outcomes contracting would be an opportunity to build the capacity of counties and providers in the model, with its much higher levels of data generation and with the mobilization of stronger performance management. Suggestions for the scope of some of these pilots are set out below, and the 'contracting framework' for a fully worked-up example is described in detail at the end of this report.

These pilot programs could, either, focus on ***purpose*** to compliment the care-based focus of the FSPs, or, explore the spaces for delivery pre- and post- FSPs. There are further suggestions in the following section to address the artificial segmentation of the system with more holistic programs targeting place or families or early intervention.

BUILDING PROVIDER CAPACITY AND THE MARKET

There is limited evidence of counties (or the State) fulfilling the vital role of market stewardship.

The performance of a County's commissioned services depends on the wellbeing of the service providers. The County must invest in building the skills and resources and motivation of their market. This can be achieved through:

- Setting informed, stretching (and deliverable) targets against which performance is fairly and transparently measured;
- Expressing these targets in terms of outcomes (not just impacts) that align the interests of the County, the service provider and the service user;
- Putting in place a performance management system that is focused on driving (and supporting) continuous improvement;
- Facilitating regular opportunities for the sharing of best practice between providers;
- Strengthening the County's communications around FSPs, to tell more clearly the story in terms of the numbers and the personal lives touched.

In order to facilitate high performance, there must be comparison and sharing across the whole State.

Suggestions are set out below for the role that the State can play in market stewardship.

The homogeneity of providers limits learning and inhibits innovation.

It is partly (possibly largely) a result of the way these services are contracted, with pressure to standardize. It will also be a result of how the market has evolved over the last 20 years, and fossilized in places. To challenge this, counties can release control over content through a shift to focus on individual outcomes (as discussed above). They can also look for ways to attract new market entrants.

There are a number of things which determine the attractiveness of contracting opportunities to new market entrants.

A new entrant will evaluate risk, through looking at:

- The size of the market, i.e. how big is the market opportunity beyond this one contract;
- Contract length, i.e. can I cover all my mobilization costs;
- Contract size, i.e. is there a critical mass, is there scale to deliver something meaningful, is there room for overheads and surplus;
- Existing evidence base of cost and performance, i.e. what is the risk of service failure;

- The procurement track record and contract management capability of the County, i.e. do they have a reputation for stability and professionalism;
- The level of control versus autonomy to deliver, i.e. will I be allowed to take the decisions I need to.

Contracting with very small service providers has advantages and disadvantages.

Some counties have purposefully sought out small, very local providers, in an attempt to better reflect the communities being served. They can potentially reach parts of the community that otherwise remain excluded. They can bring diversity and innovation. However, others commented on the 'momma and pop' nature of some providers. Small providers, by their nature, are more vulnerable to staff turnover. Their premises may be less secure for staff and service users. They have less overhead to cover things like knowledge management. With limited or no reserves, they do not have the cashflow to work with payments linked to outcomes.

There may be scope in some places to consider a 'prime contractor' model.

Some counties already have service providers who subcontract to other providers. In a pure prime contractor model, the prime is not a service provider themselves. They are contracted/paid largely on the basis of outcomes, by the service contracting body. They carry the performance risk in the system. They subcontract to networks of local providers – possibly bringing in non-traditional providers – and manage performance across this network. They may or may not use performance-based payments with their providers (in some cases, they are required simply to reimburse budgets). Sometimes it is called the 'service integrator' model because, in addressing the complex needs of the service users, the prime operates above the usual silos and knits together disparate services around each individual.

SUPPLY AND DEMAND

Our key takeaways regarding supply and demand are that the FSPs are a vital resource for those people in the system who have the very highest levels of need. They are required to demonstrate this need through repeated hospitalization and incarceration. They are likely to be homeless. They will have a serious mental illness. However, we do not know exactly how FSPs map against the actual levels of need in the community. We also note that mental health fluctuates and level of need is not static. Access to FSPs could be more straightforward, and there are people pre- and post-FSPs for whom there are limited services. There is scope for impact (and further cost savings) through closer collaboration with the justice system, particularly jails. MediCal does not cover some activities which can aid recovery, and focusing on billing alone must not preclude these. There may be a need for improved cross-working between homelessness and mental health departments, and a greater emphasis on proactive outreach. If service provider accountability is increased through changes to contracts and performance management, how also can County accountability be increased?

In relation to where FSPs sit within the overall mental health and homelessness system, we offer the following ***observations,*** with further detail on all of these following.

On eligibility, access and levels of need:

- Eligibility is tightly defined, targeting those with the most serious illness, costing the most in terms of hospitalization and incarceration;
- It's a "fail first" system, with someone having to reach the bottom before being eligible;
- It is not clear if FSP capacity actually matches the demand;
- Low staffing numbers are limiting capacity and exacerbating waiting lists (in some places);
- The counties act as gatekeeper with all referrals either going through or at least being approved by them;
- Service users all have to participate on a voluntary basis;
- In at least one County, there is a high drop-out rate from Adult FSPs in the first year;
- Some counties are trialing new community-based services to improve accessibility.

On outreach and collaboration:

- Proactive outreach on the streets can be part of early intervention and pre-empt crisis;
- Engaging with jails is important but varies greatly across the counties;

- Care Courts have mixed reputations (with some questioning whether they interfere with people's rights) but appear a strong model of collaboration that could be scaled;
- If asked, communities may select different, "non-traditional" measures of success.

Alongside these observations, we offer the following ***challenges and possible responses.***

On eligibility and access:

- Accessing an FSP can be a traumatic process for the service user and those around them, including their family;
- There is very little awareness of FSPs amongst the general public;
- There is a lack of data on the level and nature of mental illness in the homeless population;
- The FSPs target the most socially excluded people (who are likely to cost the most in, for example, hospitalization and incarceration);
- Early intervention can be very cost-effective, possibly more so;
- A single gatekeeper to the services can be a bottleneck;
- FSPs cannot bill for (many) activities in hospital and jail, which limits the service responsiveness;
- There may be a lack of understanding of and sensitivity to ethnic and cultural differences (including tribal groups);
- Someone who is socially excluded may not be willing or able to 'volunteer' for a program like this.

On a continuum of care:

- Services across the continuum are organized according to level of need but mental health needs/illnesses fluctuate;
- Identifying the group of people one or two steps above eligibility for an FSP is problematic;
- Once stabilized on an Adult FSP, there is limited or no step-down provision;
- Some important interventions are not billable through MediCal;
- Focusing on billable activities limits community engagement.

On homelessness:

- Homelessness and mental illness are conflated in the way FSPs are perceived and described, but not in how services are delivered and paid for;
- They are not experienced in silos by the mentally ill person on the street;
- Most engagement with homeless people and communities is reactive rather than proactive;
- The siloed nature of these services, with limited data sharing, limits performance.

On County accountability:

- There is no measurement or reporting of counties' performance on FSPs;
- Counties are not held to account for FSP performance.

OBSERVATIONS IN DETAIL

ELIGIBILITY, ACCESS AND LEVELS OF NEED

Eligibility for FSP participation is closely defined, with strict criteria that must be met.	The program is targeted at the people viewed to be costing the system most, in terms of hospitalization and incarceration, with the most serious mental illnesses (often also with a history of substance use). In effect, the individual must prove that they are difficult and sick enough to require a high level of care.
The counties are described as having a "fail first" system.	Someone has to fail substantially, fall right through the system, in order to access an FSP.
Once the individual has failed sufficiently, that is where they get stuck.	One County commented that if they are not on the FSP, then they are on the street. They are connected to support and services through the FSP, which otherwise they would not have.
Some counties state that the need for FSPs is fully met by the contracted capacity.	It is suggested in at least some counties that if the staffing was up to allocation across all providers, then the FSP capacity would meet the required demand, but it is not clear what evidence supports this.
Some counties report large waiting lists.	There is limited or no data on how many people are waiting for how long. There is no comparative data on this.
The counties are the gatekeeper for the program.	They manage the eligibility and approve each individual's start.
Participation on an FSP must be voluntary.	Service users have to want to join the program. This was emphasized by a number of providers and county teams as an important characteristic. There is no data to help understand what this means for the extent to which FSPs address the total addressable population, i.e. what proportion of people who would otherwise be eligible are excluded because they choose not to or are perceived as not being willing.

One County reported a high number of drop-outs during the first year of their FSP.

The programs may be 'cherry picking', with the 'harder' cases choosing to leave because the service is not flexible enough to accommodate their personal needs. It could be for a number of reasons, including the requirement for voluntary participation or the potential cultural inappropriacy of the service for certain groups. It is not clear if this is true of all providers and all FSPs, or just a subset. This would be picked up and challenged, and data would be available, if there were systematic monthly performance reviews of all contracts.

The Community Outreach Recovery Empowerment (CORE) programs in Sacramento may be a strong model to improve access.

Wellness centers were transformed into CORE centers, where people seeking mental health services can self-refer. The idea is to streamline the access process and help people in their own neighborhood.

OUTREACH AND COLLABORATION

In at least one County, there is an Outreach Engagement Team of 60 people, which is funded by and reports to the Behavioral Health Department.

This proactive engagement with people on the streets is funded as part of Prevention and Early Intervention. The County is split up into regions, with different teams responsible for particular places, and the communities encamped there. The teams refer the people on to whatever services are appropriate, and available, including FSPs (with one provider joining the Outreach Team on occasion). As this is still a ratio of around 1:130 outreach worker to homeless people, it does not allow for a very personal relationship to be built. Outreach activity is not billable through MediCal.

Engagement with jails varies between counties, and there are limitations on the services that can be provided and/or funded in jails for a number of reasons.

Under CalAIM it will be possible to claim for some interventions in jail, up to 90 days pre-release. A high proportion of people are only in jail for a week or less, which can make it hard to connect, making 'warm hand offs' difficult. As many as 50% of referrals to an FSP may come directly from jail.

The Care Courts appear to be a strong example of inter-sectoral collaboration, with a strong emphasis on individual needs.

It is an example of services coming together around the person. It also appears to be built on the notion of a 'compact', with the individual being given access to certain rights and resources, in return for accepting a number of conditions and requirements. The Care Courts are a model that could be scaled up. Though some view them as eroding trust because of where they sit in the system.

There are disincentives for FSPs to engage with people who are locked-up in hospital, with no billing allowed for in-hospital engagement.

Incarceration for someone with a serious mental illness may mean being locked up in hospital.

In one county, we heard about a "culturally responsive and congruent" program in four county-run clinics designed in consultation with local Black American communities.

This included activities like art therapy. It was said to focus on things like social connectedness and employment, as opposed to "traditional measures".

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

ELIGIBILITY AND ACCESS

We met with a group of people from the National Alliance on Mental Illness (NAMI). They were all the parents of people now on Adult FSPs. They also all told an incredibly moving story about the extreme difficulty that they had to, (a) find out about the FSPs in the first place, and (b) get access for their (adult) child. In most cases, they had been forced to have their own child repeatedly arrested. This was in a County with (at least anecdotally) high-performing FSPs, managed closely by a highly capable County team.

These parents spoke highly of the level of care now provided by the FSPs to their adult children. But there is no support for the parents themselves to cope with the deep trauma that they continue to experience.

Potential service users, and their families and other community members, are generally unaware of FSPs.	The systems appear from the outside to be opaque and highly complex, with little or no general public awareness of FSPs or other services. The segmentation of the 'continuum of care' by intensity, creates further complexity which inhibits effective access.
There is no clear data on the level and nature of mental health in the homeless population.	By virtue of their life on the street, all of this group will be experiencing daily trauma. They will live constantly with high levels of stress (with all the concomitant physical impact of this). The percentage with serious mental illness is almost certainly not matched by the number of places on an FSP.
The system targets those who are most socially excluded by virtue of their mental illness, because these are deemed to be the most costly to other services.	This group is incurring the high costs of hospitalization and incarceration. Stabilizing them (e.g. ensuring that they take their medication) appears quickly to relieve this pressure on services and this cost. But, this is achieved with an expensive, high-intensity response, with very small caseloads and large, professionally trained teams including clinical staff. Currently, on an Adult FSP, they are also likely to remain on that expensive program for many years.

Targeting people who are closer to 'home' and social *inclusion,* such as those newly arrived on the street, would potentially deliver a greater return on investment.	Someone who is recently homeless is likely to have a simpler set of needs than someone who has spent years there. Their body and mind will not yet have deteriorated as a result of that existence. They may appear to be less costly to the County/State, in the short-term, because they are not as often in out of hospital/jail, but they are at high risk of becoming as expensive, in the long-term. And as soon as they hit the street, they are already a social cost. At the same time, addressing their needs, such as helping them to reconnect with their family or to find a job, could be achieved much more quickly, and much more cheaply. Early intervention programs tend to be targeted at children not newly homeless adults (or families).
As gatekeepers for the FSPs, the counties may make entrance harder and disincentivize providers from seeking out new service users.	Having a single gatekeeper can create a bottleneck, when there are actually a wide number of touchpoints through which a service user could be identified. There is a lack of incentive for the service providers to keep pushing for higher volumes, which would incentivize them to challenge the silos in which these touchpoints operate.
There are lines drawn around FSP eligibility and participation, which don't reflect the nature of the targeted population, notably around hospitals and jails.	FSPs are not able (or cannot claim the time) to visit a service user in hospital or jail. There is, at least, a disincentive to do so. They cannot, for example, go into hospital to maintain care and possibly speed release, and ensure release means moving into a safe, stable place.
There was no reference in any of our discussions to the different experience of different ethnic groups, either in relation to mental health or to FSP performance.	There is data showing the disproportionate numbers of some ethnic groups on the street and suffering from serious mental illness. There is also data on the ethnicity of FSP service users (though with big gaps in that data). Do all ethnic groups manage to access FSPs in the same proportions? Are there any barriers, real or perceived, for any groups? Once on the program, do all groups progress in the same way and is there parity of outcomes?
We have been unable to ascertain the intersection of FSPs and tribal communities.	It is not clear the extent to which tribal groups are at particular risk of homelessness and serious mental illness, whether they have access to appropriate FSPs, and what outcomes they achieve.
Emphasizing the voluntary nature of the FSP may limit its reach and fails to account for the nature of social exclusion.	One provider talked about "harm reduction" as opposed to "treatment" because of the need to not impose on the service users.

A CONTINUUM OF CARE?

The way the system is organized, does not reflect the nature of people's lives (particularly if living on the street) or the nature of mental health.	Attempts are made to deliver a continuum of care that is segmented according to level of need and/or intensity of service (and as residential and non-residential). The FSPs are targeted at those who are ***most*** in need. However, this does necessarily reflect the true nature of need, or of mental health more generally, which fluctuates. The organization of services needs more closely to reflect this natural fluctuation, including the possible movement in and out of residential care (without this creating a gap in provision). Is there a better way to segment services, possibly by place or by priority group (e.g. homeless families) or outcome (e.g. employment)? Or is there a way to allow movement between services, without creating gaps that people fall through?
It is extremely hard to define the group of people whose level of need is one or two levels up from an FSP, or to define how the response to their needs would be different.	If we wanted to implement a Pre-FSP program, how would we delineate this group? The needs of this group, and their desired outcomes, would probably look very similar to the FSP group.
On the whole, there is no clear next step for most Adult FSP service users to progress on to as they are stabilized.	There is no coherent Post-FSP provision. There is also limited incentive for the service providers to transition service users onto lighter-touch support, whilst keeping them on the FSP.
Some of the service constraints are obviously imposed by MediCal rules.	If a young person has an eating disorder, the FSP can provide (and claim for) family therapy, but MediCal will not cover the cost of a dietician and there is no registered MediCal facility should the young person need residential care.
The focus on billable activities mitigates against community engagement, which an outcomes-based model might encourage.	In many places, particularly where the provision sits within a small, close community, the members of that community may have a role to play in supporting the service user to secure and sustain independence. If this was the function and goal of the FSP, then the provider would be incentivized to reach out for community support. Though this would not be billable under MediCal.

HOMELESSNESS	
The homeless and mental health population are conflated in the program objectives.	But the services deployed in response to these are largely separate and siloed. FSPs view themselves as a mental health, not a homeless, service. One provider reported that people try to access their program in order to secure housing and are told that it is a mental health program (which may provide housing on a short-term basis).
This separation fails to account for the holistic nature of life experience.	The system looks to separate homelessness and mental health in the way they are funded and delivered. For the individual, their homelessness and their mental health are intertwined.
Different counties deploy different teams to engage with homeless communities, but this is largely reactive.	In most instances/places, there is an emphasis on reactive responses to homelessness (and mental health) through, for example, crisis helplines, with some good practice shifting this away from the police. Behavioral Health in some counties also deploy assertive outreach or engagement teams.
Homelessness services generally sit in another department and have separate oversight.	(Notwithstanding the example above of a team of 60 outreach workers) there is fragmentation and duplication of these services, with no data sharing and with, as a consequence, weakened accountability.

COUNTY ACCOUNTABILITY

There is a lack of clarity over exactly what counties are accountable for in terms of FSP spend and impact.	This may be related to the lack of clarity over whether the programs are about reducing hospitalization and incarceration or about improving individuals' wellbeing (and enabling their independence) – which may come to the same thing but ultimately shape different services.
There is no mechanism to hold counties to account for FSP spend and impact.	If there were transparent comparative data on FSP performance, the counties would be better equipped (and incentivized) to intervene when providers underperform. If a County consistently underperforms, then in what way are they held accountable? A potential mechanism might be as follows: 1. a performance improvement plan is agreed and the County is given the opportunity to remedy the situation; 2. continuing failure results in a further level of actions including a change in the management staffing and structure; 3. further failure and responsibility for FSP contracting and direct delivery is removed from the County and given to a neighboring County demonstrating high performance; 4. ultimately, the State may take over direct management.
A large proportion of the FSP target population also have a substance use disorder and this report has not considered the relationship between FSPs and substance abuse services.	This will have to be explored in the light of proposed changes to MHSA legislation.

WORKFORCE/STAFFING

Our key takeaways regarding workforce and staffing are that the staff working on FSPs are the heart of the performance of these programs. They are, on the whole, highly professional and committed. They entered the profession with a desire to make a real, positive difference. They tackle some of society's most difficult challenges. However, service providers are struggling to recruit and to retain staff. Some providers are doing better than others, but there is no systematic sharing of best practice. Many providers also do not appear to understand the basic link between investing in staff and hitting their contract cap in earnings. Outcomes contracting would reinforce this link, with better quality and more motivated staff delivering higher outcomes (and income). Some of the current service culture and system changes are driving down motivation and increasing stress levels. The State and counties, in consultation with stakeholders, must consider a strategic response to address this.

If contracts across the State are running at 70% of capacity – with 30% underspend across the system as a result – and the single biggest cause is difficulty to recruit and retain staff, then something different has to be tried.

In relation to the challenges faced by FSPs regarding the workforce, we offer the following ***observations:***

- Most providers are struggling to recruit staff, with up to 50% gaps in staffing in some places;
- Turnover varies between locations and between providers;
- There are examples of good practice in recruitment and retention;
- Some recruitment systems have been very bureaucratic and burdensome;
- The workforce does not match the service user demographic;
- Stress levels are high, so sickness levels are too;
- Peer workers add a lot of value;
- The performance management of staff varies between providers;
- There is budget available to fund education and training.

Alongside these observations, we offer the following ***challenges and possible responses:***

- Some providers are coping better but there is no sharing of this best practice;
- Most providers lack business models to give them a sensitivity analysis of the business impact of low staffing, and the value of investing in this;

- The drivers of stress include a lack of perceived control, burdensome admin and the emphasis on billing;
- Targeting billable minutes may squeeze out things like staff training and team meetings;
- Staff management and development will focus on the contracted targets, i.e. maximizing billing, as opposed to meeting service user needs;
- Contracting and paying for outcomes (personal, service user level outcomes) would incentivize providers to invest in staff;
- As 'market stewards', the State and the counties need to develop a strategic response to the workforce challenges.

These observations and challenges are set out in further detail below, along with some ideas for counties and State to consider. The development of a joint strategic plan is suggested.

OBSERVATIONS IN DETAIL

Most (but not all) of the service providers are struggling to recruit the full headcount of staff needed to service their contracted volume of service users.	It was reported that the vacancy rates are highest on the most intensive services, with up to 50% of positions unfilled on stabilization services (i.e. short-term assistance for people leaving hospital).
The turnover rate varies between providers and between locations.	Some point to the extra challenges of rurality and others to the very high costs of city living. The biggest variance appears to be between providers, reflecting different organization cultures and employment practices.
The service providers with the lowest turnover use a number of different strategies.	They look to over-recruit throughout the year. They may use an external recruitment company, which is incentivized/ rewarded to fill positions (unlike their internal HR services). They also look at the staffing model itself and shift to use accredited peers more or paid interns (many of whom progress to permanent positions).
The time taken to recruit has been as high as 250 days in some places.	There is a lack of incentive to be efficient in some parts of the recruitment system. This further deters candidates from applying. There is also a long time taken between job offer and job start.
The demographics of the workforce do not match that of the service users.	In one County, they introduced additional criteria to address this, including a requirement for lived experience. This may have reduced the pool further if it was not accompanied by proactive attempts to change the nature of the recruitment process (and possibly the nature of the employment itself) to be more inclusive of different populations.
There are reports of high levels of stress across the workforce, which is likely to be a driver of high levels of sickness and turnover.	Staff clearly experienced stress adapting and continuing services during COVID. Transitioning away from COVID brought further stress. The introduction of CalAIM is adding pressure to the frontline, along with new IT systems, new paperwork and probably legislative change. As staff leave, this adds pressure to those that remain.

The use of peers appears to be growing and this strengthens the service considerably.	The peers are more likely to match the service user demographic. Service users may open up more with peers, and can draw on their personal experience. The peers may help to ensure services are centered on users. Models such as the Club Houses appear able to deliver strong outcomes.
There is considerable variation in the capacity and commitment of providers to performance manage staff.	Performance management of staff appears to be left to supervision by many providers. A lack of performance management may be the result of: • a lack of positive outcomes measures across the service as a whole (it is much harder to manage against the negative measures such as not being hospitalized); • concern over turnover and not wanting to lose more staff; • lack of capacity/expertise at the team leader and lower management levels, or; • the lack of a performance culture across the system.
The Workforce Education and Training (WET) budget includes providing funding for educational loan repayments, undergraduate scholarships and post graduate stipends.	This is centrally administered. It removes some of the financial barriers for participation in training. However, it does not necessarily proactively look to increase the volumes of trainees.

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

Some providers appear to be tackling the recruitment challenges better than others, but there is no sharing of best practice.	Sharing comparative performance data, including ability to maintain headcount, would highlight the outliers.
No providers, or counties, have undertaken a sensitivity analysis showing the relationship between the cost of a member of staff and the income they can generate.	This would enable the setting of salary levels to be more informed and could challenge the persisting low headcount and reduced capacity.
The lack of performance management of staff limits service performance.	Performance management is about setting clear goals and objectives, and managing against these. It gives staff clarity over their role and reward/recognition improves motivation. It helps to identify the development needs of staff and can help inform, for example, in-service training.
Stress is significantly increased by a sense of lack of control.	The more the program is homogenized, and 'whatever it takes' is squeezed out, the more staff will experience stress. This will be exacerbated by a growing emphasis on replicating billable activities and maintaining records according to strict templates.
Stress is significantly decreased by a sense of delivering a meaningful purpose.	Adult FSP teams in particular do not currently measure or focus in any way on identifying and delivering purpose. They are focused on reducing hospitalization and incarceration, not helping someone to identify a dream and achieve it. The key events that are recorded are, for example, someone being arrested, not someone meeting up with their family or starting a job. What key events do the member of staff or the entire team celebrate?
Providers report a tension between maintaining activities like staff training and team meetings, and maximizing billable activities.	Many providers will simply conform to the culture created by the contract and will not recognize the long-term return from investing in staff development. They will disinvest in staff training and the meetings that build teams and support motivation.

Staff development will focus on what is needed to make the contract successful.

Staff right now are being trained on how to complete paperwork and how to maximize billing. Training is not fueling the motivations that brought these staff to this sector in the first place. It is not investing in building skills that they value.

Service providers cannot be mandated to deliver better staff management, but can be incentivized to invest in order to achieve higher performance.

If there is a culture of performance across the system, driven by the tracking, reporting and rewarding of meaningful, positive outcomes, then providers will look for ways to deliver more. They will naturally look at how to develop their most important resource, through hiring better and employing better. This can be facilitated by the counties/State, in their role as 'market steward'.

There has been a limited strategic response to workforce stress and to the need to maintain high motivation.

In the role of 'market steward', what steps can State and counties take to address the workforce challenge which is so constraining current FSP performance? Responses might include:

- Bringing providers (and other stakeholders) together to share best practice and agree an action plan;
- Review and revise the way performance is defined, measured, reported and reviewed. If needed, the contracts can continue to maximize billing as well as focus on individual, purposeful outcomes;
- Pilot the programs proposed in this Report, to create opportunities in the system for variation and innovation, and for purpose-driven services;
- Through the pilots, bring in new market entrants with different staffing models;
- Review and revise the staffing models that are contractually required, and consider a greater use of peers;
- Specifically address the inability to bill for staff training time (though a shift to outcomes payments is by far the best way to incentivize investment in staff);
- Review the sign-offs required, for example, for flex funds, to increase the sense of autonomy and empowerment among the staff;
- Undertake a mapping exercise of data flow and look to rationalize data entry;
- Explore whether there are ways to capture billable minutes behind the scenes, freeing up frontline staff to focus service users. What examples are there of best practice in physical health services?

- Consider how to stimulate the supply of labor, with recruitment targeted at non-traditional populations, through new performance-based contracts with recruiters;
- Contract an organization to grow the numbers and skills of peers (from youth to old age), with the contract performance measured/paid on the basis of peer volunteers engaged, peers trained and subsequent peer-on-peer interactions (if remotely, then monitored by a combination of AI and human coordinators).

APPENDIX II:
THE 11 CHARACTERISTICS OF HIGH-PERFORMING CONTRACTS

High-performing contracts will address these 11 questions as follows:

1 ***What does success look like?*** There is a strong, clearly articulated definition of high performance that all stakeholders buy into and understand, including service users, who are heavily involved in shaping the definition. Success aligns the interests and incentives of all stakeholders and covers both programmatic and financial objectives as well as individual outcomes. The definition of success is agreed upon at the start. On a program addressing mental illness and/or addiction, consideration is given to all three domains of People, Place and Purpose (see below).

2 ***What is being purchased?*** Payments to Service Providers are tied to highly relevant and easy-to-understand deliverables that reflect high performance. These might be inputs, outputs, outcomes, or possibly even impact[7], but the emphasis should be outcomes. Deliverables are measurable, verifiable, limited in number (between four and eight is optimal) and assessed at the individual service user level. Deliverables are designed to create a culture of high-quality service that drives frontline behavior and are instrumental in guiding the performance management of staff. In addition to deliverables that trigger payment, there needs to be minimum service standards that are not tied to payment but are built into and required by the contract (such as maximum response times or minimum levels and frequency of contact with service users). In some contexts, there will need to be a separate 'verifier' who independently checks that deliverables have been achieved in order to trigger payment.

3 ***At what price?*** The pricing attached to deliverables must be programmatically informed and relevant, incentivize performance and drive efficiencies. Pricing is derived from an analysis of the inputs/expenditure required to achieve the targeted level of performance. The cheapest offer from service providers is not necessarily the best when the primary objective is a service that maximizes outcomes. The question is not, 'how cheaply can you do this?', but 'how many high-quality outcomes can you deliver for the money that is available?'

4 ***How much is paid when?*** The payment schedule balances the need for working capital with incentivizing performance. Payments are tied as far as possible to outcomes but the County and the provider understand the cashflow implications and ensure this is addressed in some way. The optimal balance of outcomes versus budget reimbursement or input payments is with 2/3 of payments linked to outcomes. All payments to providers are scheduled and efficiently administered (with monthly invoicing and payments made within 20 working days).

[7] For example, an input is someone receiving training, an output is someone gaining a qualification, an outcome is someone securing and sustaining employment, and an impact is a reduction in % of unemployment.

5 ***When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?*** Service users and peers are involved in the design of the program and throughout delivery. Giving service users the ability to select some or all of the payment triggers can help to put ownership in their hands and empower them. Users, families and peer advocates will also be given a seat on any performance review board or committee. There are regular satisfaction surveys.

6 ***How is the target group defined and who controls referrals of service users onto the program?*** Careful delineation of the targeted population and definition of eligibility criteria mitigate 'deadweight' (people who could have achieved the outcome by themselves, without the program) and 'creaming' (i.e. providers choosing 'easy' people to work with). These criteria are kept under review and may be varied on occasion to ensure high referral numbers. Volumes are a key performance driver and the service provider controls or at least can influence the flow of service users, for example, being able to undertake outreach to secure new clients. A high performing contract incentivizes the service provider to deliver as many outcomes for as many people as possible, who could otherwise not have progressed.

7 ***How is frontline activity and performance recorded and facilitated?*** All activity delivered on the frontline is recorded and can be analyzed, quantitatively and qualitatively, at different levels (e.g. at individual staff, team, office or contract level). A good IT system for capturing frontline activity enhances service quality and facilitates efficiencies day-to-day (e.g. with accessible case management tools, diary reminders, template letters or automated text messaging). Consideration is given to how the IT system (or app) impacts the workload and motivation of staff; double data entry into different systems is avoided.

8 ***What is the performance management structure/system?*** There is a systematic review of performance. There are monthly performance reviews by a Performance Board where the provider presents to the contract manager and other relevant parties as indicated. Performance is tracked at an individual service user level, and includes 'exception reporting', i.e. who has not been seen in the last month and for what reasons. The objective is to seek continuous performance improvement, asking each month, 'what do we need to be doing more of?' as well as 'what do we need to be doing differently?'. Performance is reported transparently with regular publication on a website. There is regular (e.g. monthly) performance comparison between providers.

9 ***What are the consequences of under-delivery or other disagreements/violations?*** The contractual terms are clear on 'step-in rights' when performance standards are not met, e.g. the provider is required first to draw up an improvement plan and then implement changes as agreed. There may be adjustments to the payments, referrals may be stopped for a period of time, the provider might have to change their managers, or, ultimately, the contract may be terminated. Service failure might result from failing to meet performance targets or failing to meet quality minimum standards.

10 ***What assurance model oversees performance?*** Service providers have in place a robust, systematic audit and assurance process to verify the deliverables/outcomes that are claimed including the quality of the service received by each service user. The County audits the provider's systems and undertakes additional auditing as indicated, based on the evaluation of risk.

11 ***How does the service contracting body (i.e. County Director) fulfill the role of market steward?*** The performance of the program depends on the wellbeing of the service providers – on them being able to perform at their best, with the right resources and with high levels of motivation. The State and County think about how to build the service providers' capability, investing in capacity building activities and bringing providers together to share best practice. This is underpinned by transparent reporting of performance across all providers – the focus always remains maximizing outcomes for service users.

APPENDIX III:
OUTCOME DOMAINS (I.E. DELIVERING ON 'PEOPLE, PLACE AND PURPOSE')

Being part of a community, or simply having community in life, is a requirement for, and core indicator of, overall health and wellbeing. In general, human beings with strong community flourish while those without it languish. At HBGI, we use three life domains[8]: ***People, Place*** and ***Purpose,*** to define community.

These domains can be used to assess and track the trajectory of an individual client's progress as they receive care interventions in the pursuit of recovery from mental illness and/or addiction.

Metrics of relevance in each of the three domains include the following.

People, or 'someone to love', provided, for example, through peer support, family reunification or socialization programs. This might be measured in terms of:

1. Capacity to care for and be cared for by others, including family/kin;
2. Contact with, and connection to, family of origin and or equivalent kin;
3. Current and ongoing fellowship/support from friends and/or colleagues.

Place, or 'somewhere to live', such as housing, a clubhouse or peer respite programs. This might be measured in terms of access to:

1. A dignified, safe, secure and comfortable living environment (housing);
2. A space for convening or center of gravity for social and recreational activity;
3. A calm and easily accessible sanctuary (e.g. for relaxation mindfulness/meditation).

Purpose, or 'something to do', which might include developing hobbies, education/training, volunteering (including providing peer support), or employment programs:

1. A sense that there is meaning in the activities of life (a personal mission);
2. A pattern of activities that reflect, and/or stances that represent, mission;
3. A job and/or vocation that empowers both livelihood and independence.

The precise outcomes measures (and/or payment triggers) for each one will depend on the context and should be agreed in consultation with all stakeholders – and should meet the criteria set out on the 11 Characteristics (notably being measurable and verifiable). As noted elsewhere in this report, performance can be significantly enhanced through a shift of control to service users, giving them the ability to define (or select from a list of options) their own expression/measures of People, Place and Purpose outcomes.

[8] Based on the work of Dr Jonathan Sherin, co-author of this report.

APPENDIX IV:
AN ANALYSIS OF THE ADULT FULL SERVICE PARTNERSHIP (FSP) CONTRACTS

There is clearly variation in FSPs between counties and between contracts. The following analysis describes the prevalent characteristics observed during preparation of this Report (with a focus on Adult FSPs) against the 11 characteristics of high-performing contracts and the domains of people, place and purpose.

Target Model	FSP Observations	Recommendations
1. What does success look like?		
Clear definition of high performance understood by, and aligning the interests of, all stakeholders.	Success stated mainly in terms of impact, namely high-level reductions in homelessness, hospitalization and incarceration. Missing individual service user outcomes (notably around Purpose). Emphasis on a 'medical model' and identifying what's wrong with service users. Treatment rather than recovery.	Continue to track impact on homelessness, hospitalization and incarceration. Agree new outcome-level targets, at the service user level, and new monthly reporting. Pilot new contracts with 'success' defined clearly in terms of outcomes, including around Purpose.
2. What is being purchased?		
Payments attached to (4 to 8) relevant, measurable, verifiable deliverables, focusing on the individuals, creating the right culture, driving frontline performance. With minimum quality standards established alongside.	Mainly a pre-agreed budget, with key specified staffing numbers to manage a maximum caseload size/contract volume. A largely homogeneous service, becoming more so with a push towards fidelity or near-fidelity ACT. Provider payments moving towards a link with MediCal billing, with providers targeted to maximize this.	Introduce a blended payment model with 50% of the payments to providers partly linked to MediCal billing and partly to individual service user outcomes. Define minimum service standards but leave providers room to innovate to achieve outcomes.

Target Model	FSP Observations	Recommendations
3. At what price?		
Pricing recognizes commercial reality of delivery, considers the link between inputs/costs and outcomes/income, and incentivizes high performance.	Very high variation in FSP cost from County to County. Possibly fossilized business models with costs becoming fixed over time. Variation in procurement practice but generally a mix of technical and cost evaluation, sometimes with past performance.	Look to compete future contracts on performance rather than price. State the budget available and ask bidders to state the number of outcomes they will achieve within this budget – that sets the price per outcome. Require bidders to submit fully costed plans showing the cost of all inputs and the rationale behind their performance offer.
4. How much is paid when?		
The selected payment triggers take into consideration provider cashflow. Payments to providers are administered efficiently.	Flat monthly budget reimbursement (i.e. annual overall program cost is divided by 12), moving towards link with MediCal billing and monthly variance. Flex funds appear to be utilized well in some places though no data on this (and strictly controlled by the counties). Small incentive payments have been trialed in some places without success.	Monthly submission of invoices based on the month's performance (e.g. outcomes achieved). If cashflow is a concern, pay the first six months anticipated earnings upfront and then readjust in the light of actual performance. Verify a sample of all outcomes claimed and clawback funds if there is no evidence. Build the flex funds into the overall contract value and give control to the providers to maximize their outcomes. Providers to record all spend.

Target Model	FSP Observations	Recommendations
5. When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?		
Wide stakeholder engagement from the outset, including lived experience. Service users given clear sense of ownership.	Service specification is very top down. Families/advocates are closely involved in Child FSPs but much less, if at all, in Adult FSPs. There is increasing, valuable use of peers. Limited program oversight overall.	Service users to select their own desired outcomes across People, Place and Purpose. Service users, families, peers and advocates to be consulted in drawing up the lists from which the outcomes are selected. Families to be surveyed following a service user's start on an FSP regarding their experiences accessing the service. Monthly Performance Board to include service users, peers and possibly advocates, as relevant in that setting.
6. How is the target group defined and who controls referrals of service users onto the program?		
Referrals are not a blocker. Providers are incentivized to seek high volumes. Eligibility criteria mitigate 'deadweight' and 'creaming'. Eligibility criteria kept under review.	The counties generally act as the gatekeeper. This can cause bottlenecks. People must really 'fail' in order to access the program. It is not clear if there is the right match of supply/spaces and demand/service users at present. Spaces are awarded to those who have failed the most loudly. Major constraint on being able to make referrals at the moment is lack of staffing in the providers. There are waiting lists of service users in some locations. There is little public awareness of FSPs.	Widen referral routes and incentivize service providers to go out to engage potential new service users (including onto the street and into jails). Review the forms used to screen referrals to ensure they aren't overly bureaucratic. Extend Care Court collaboration. Move to outcomes-based payments, with the potential for over-performance, to incentivize providers to look for higher volumes. Pilot a Follow-On program with lighter-touch support, possibly with an emphasis on peers, to create space on the FSP. Pilot place-based programs to take the services beyond FSPs. Review communications activities to raise public awareness.

Target Model	FSP Observations	Recommendations
7. How is frontline activity and performance recorded and facilitated?		
Activity is tracked, recorded and reported. IT/case management systems help not hinder staff performance.	Variation between counties and providers, with some good practice (though it is the exception). An emphasis on accurate recording of activity according to MediCal requirements - with reporting on billing 'productivity'. Double or triple entry into IT systems. Staff stress/motivation a concern.	Review all IT system use. Map data flows. Consider impact on staff and time taken to enter data (in multiple systems). Review case management tools available to case managers. Look for examples of good practice in physical health programs with systems recording billable activities in the background. In the workforce strategy, plan for ways to address staff stress. Build provider capacity in stress management. Shifting focus to recovery outcomes will reinforce the positive purpose of the program.
8. What is the performance management structure/system?		
Monthly performance reports published and reviewed. A systematic search for continuous improvement.	Occasional high-level reports on the three impacts (percentage reductions in homelessness, hospitalization and incarceration). No link back to individual progress on the program. Some monitoring reports produced in isolation from delivery. No transparent reporting of performance. No comparison across contracts/providers. In a small number of cases, there are monthly performance reviews. Most providers do not even undertake this internally.	Continue the high-level reporting. In addition, introduce: • Monthly reporting. • The production of a monthly Performance Pack, which is reviewed by a Performance Board. Membership of the Board to include operational leaders from the provider and possibly peers, advocates and service users. The County Monitor (or equivalent Contract Manager) to attend at least quarterly. • Consolidated performance reporting across all providers – monthly in the County and quarterly in the State.

Target Model	FSP Observations	Recommendations
9. What are the consequences of under-delivery or other disagreements/violations?		
Clear 'step-in rights' in the event of underperformance.	On occasion, action plans are requested. Terminations are very rare and largely due to financial failure.	Monthly Performance Boards to capture agreed actions, looking each month for continuous improvement. Review service provider contracts and add clarity on 'step-in rights' for minor and major performance failures.
10. What assurance model oversees performance?		
Providers have quality assurance systems in place. The service contracting body audits these and possible assures directly based on risk.	Reliance on layers of supervision. Some evidence of wider quality assurance systems in larger providers.	Providers to review their internal systems. Providers to present this review to the County and, together, decide the strengths and weaknesses. County to consider how to audit this assurance system and if/how to undertake direct inspections or observations. County thereafter to conduct a periodic risk analysis and determine their audit regime in response. Focusing on personal outcomes will strengthen the personal responsiveness of the FSP.
11. How does the service contracting body fulfill the role of market steward?		
The service contracting body invests in supporting and growing the service providers, with capacity building and best practice sharing.	Little or no sharing of best practice across/between service providers. No systematic engagement across the sector. The Association of not-for-profits is about to open to for-profits too. No sharing of lessons between in-house and contracted provision.	County to convene an initial meeting of all providers. Share an overview of the County services and the FSP contracts and performance. Present the service improvement plan. Brainstorm ways to support, collectively, provider development (always with a focus on performance). Continue with at least twice-yearly best practice sharing days. State to echo this, with State-wide engagement and an annual conference (convened in partnership with the provider Association(s)).

Target Model	FSP Observations	Recommendations
People		
Service users are meaningfully connected with others, such as peers, families or other social networks.	Close involvement of families in Child FSPs. Possible active disengagement with families in Adult FSPs. Increasing use of peers. Adult FSPs likely to run a range of group activities and appear to build positive/supportive connections between service users.	Agree desired outcome(s) with service user regarding social connections outside the FSP. Track progress against this. Consider how to establish (and fund) family support in parallel with the FSP.
Place		
Service users have somewhere safe, secure and stable to live.	Sourcing good housing options is a challenge in all areas. However, high proportion of service users secure accommodation. Club Houses and peer respite programs used well where they exist.	Look for best practice on homeless programs elsewhere. What innovative models have been used to create space and also to finance it? Explore the use of rent guarantees and landlord insurance schemes. Consider the use of Impact Bonds with private finance paying for property development against a guaranteed income stream of rent underwritten by the County. Consider the potential for cooperative construction projects, with the service users building their own future accommodation. Consider re-purposing disused office space, possibly in partnership with Club House organizations to ensure community spaces and activities are integrated.
Purpose		
Service users are connected to activity that gives meaning and independence, such as employment.	Child FSP service users move on after 12 to 18 months (maximum). Adult FSP users appear to become stuck on their FSP, possible reinforcing their dependency. An emphasis on keeping them safe and stable. There is little evidence of purposeful goal setting. Some employment advisors being embedded in teams now.	Pilot a program in parallel with FSPs that pays the provider to support people into work (possibly training and supported employment too). When recontracting FSPs, split the provider payments between billable activity and outcomes. Look as far as possible for the measurable, verifiable outcomes to be selected by the service user.

APPENDIX V:
THE FRAMEWORK FOR A PARALLEL PURPOSE-LED OUTCOMES CONTRACT

The following table takes the same 11 Characteristics, and sets out the answers for an outcomes contract that might run in parallel with an Adult FSP, focused on Purpose through (training and) employment. This is by way of example, with many of the details in practice to be agreed in consultation with the relevant stakeholders.

Purpose-led outcomes contract – focus on employment

1. What does success look like?

The overall objective is sustained employment for as many people as possible. Success is people engaged in activity that they perceive to be purposeful. This may mean participating in education, training or supported employment and progressing to full employment, or going straight into work. It might mean establishing an Intermediate Labor Market to create supported employment opportunities (such as recycling furniture), as long as there is a clear progression to full employment.

2. What is being purchased?

At least 65% of the payments to the providers are linked to job entry and sustained employment. The employment must be sustained for at least three months (13 weeks) and it could include two different jobs during that time (with no more than a two-week break between them).

The total contract value is split 10/10/15/30/35:

- ***10%*** for enrolments, with agreement on a job goal (possibly short-term and long-term goals, which may be revised later) and completion of an Action Plan;
- ***10%*** for completion of education or training (with certification);
- ***15%*** for completion of up to three months of voluntary work or supported employment;
- ***30%*** for starting a formal job (with a letter of appointment or work contract as evidence);
- ***35%*** for sustained employment (with pay slips or other evidence of ongoing work). The employment must be in a 'good' job, the detail to be defined (e.g. in terms of minimum number of hours per week, salary, travel distance to work from home, match with job goals, in a safe environment). If someone moves straight to work without training and/or supported employment, these payments can be rolled up and added to the job start payment.

3. At what price?

The budget is capped at $10m per provider, to be split 10/10/15/30/35 as described above. Potential providers submit bids setting out their technical proposal and saying how many enrolments, training completions, supported employment completions, job starts and sustained employments they can achieve. If their bid is successful, this determines the unit price that they are paid for each of these deliverables.

Bids are evaluated 80% on technical offer and 20% on price. Once mobilized, the provider can over-perform on the job starts and sustained employment outcomes/payments (not on the training or supported employment), and claim up to $3m over the $10m (i.e. 30% over their base targets).

4. How much is paid when?

Service providers submit an invoice at the end of each month detailing the individuals and the deliverables achieved. They must submit evidence to support each claim (e.g. copy of identification at enrolment, certificate after training, work contract or letter of appointment, etc.). The County audits this claim and then pays the invoice within 20 working days.

In order to allow providers to bid and participate who do not have large reserves or the ability to borrow, the County may consider paying an upfront 'mobilization allowance'. This will cover the early cash gap ahead of the earnings from the outcomes. The provider 'repays' this upfront money once they start to deliver outcomes (i.e. it is deducted from invoices).

5. When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?

As an outcomes contract with a strong focus on jobs and sustained employment, the service provider must listen to each individual participant and build the service around their individual needs – or they won't be able to achieve any outcomes. The service is highly localized, around the individual and their community.

The monthly Performance Board includes representation from participants and/or peers and advocates.

6. How is the target group defined and who controls referrals of service users onto the program?

Participants must be unemployed. They may be attending an FSP but not necessarily. They have a diagnosed mental illness or addiction. The service provider is responsible for establishing referral channels and for achieving their contracted volume.

7. How is frontline activity and performance recorded and facilitated?

Service providers use a case management system to record (and report) all activity with participants and to support the work of their case managers. It is possible to report activity (including outcomes) by individual and by cohort, in the month and cumulatively. The strength of their system is evaluated as part of their bid.

8. What is the performance management structure/system?

The contract has payments weighted on outcomes to incentivize performance. Service providers submit a weekly report of all activity. On a monthly basis they present an analysis to the Performance Board. The Board is chaired by a County representative. There is a minimum of two providers to mitigate the risk of one failing and to allow for comparison of performance.

9. What are the consequences of under-delivery or other disagreements/violations?

The service providers are only paid if they deliver the outcomes. Targets are derived from the bid for enrolments, training, supported employment, jobs and sustained employment. If these targets are being missed and the Performance Board is concerned, then, in the first instance, a Performance Improvement Plan is agreed. If targets continue to be missed, then a formal Improvement Notice is served. Finally, the contract may be terminated and the service transferred to another provider.

10. What assurance model oversees performance?

The service provider implements their own quality assurance system, which is in turn assured by the County. Summary Quality Assurance reports are included in the monthly Performance Pack. The quality of the outcomes is also controlled by definition of minimum standards (e.g. hours of work, salary, etc.).

11. How does the service contracting body fulfill the role of market steward?

During procurement, the County runs a series of briefing events, which include capacity building for all interested providers on: outcomes contracting; building an outcomes contract operating budget; mobilizing outcomes contracts, and; strengthening performance management.

On a quarterly basis the County convenes a meeting of all service providers. Performance across the service is reviewed and key lessons from the Performance Boards are shared.

APPENDIX VI:
A NOTE ON TECHNICAL ASSISTANCE

If the State and/or counties decide to implement any of the recommendations set out in this Report, they will look to bring in Technical Assistance (TA) to support this. Their own resources are stretched thin and there are already a number of other initiatives underway. The TA should be looking to enhance performance – increasing efficiency and effectiveness - without putting pressure on existing delivery.

The specific opportunities for TA support include:

- Revision of the payment terms and performance measures for existing FSP contracts;
- Amendments to existing, or new, contracts to pilot an FSP Follow-On;
- Piloting a purpose-led outcomes contract to run in parallel with the FSPs;
- Piloting an outcomes contract focused on reducing jail re-entry;
- Piloting an outcomes contract targeting particular homeless communities with special consideration of homeless encampments;
- Agreeing upon new performance measures with the FSP providers and implementing new performance management and performance reporting (e.g. the production of monthly reporting 'packs');
- Introducing monthly performance 'boards' to review progress and drive continuous improvement;
- Introducing new transparent comparative performance reporting across contracts and providers within a given County and between jurisdictions.

All counties have specific challenges. Counties may review this Report and identify different approaches to address the recommendations here in terms of amended or new contracts or ways of working, that would benefit from TA.

It is recommended that the TA commissioned to support the implementation of any recommendations set out in this Report should be able to evidence the following experience:

- Considerable senior leadership in the design, mobilization, direct delivery, contracting and oversight of services targeting the most vulnerable populations, in multiple countries and contexts, including for people with physical and mental health conditions, addictions, unemployment and homelessness, with an emphasis on experience in contracting and monitoring services on the basis of performance and outcomes;
- Considerable senior leadership in the design, mobilization, direct delivery, contracting and oversight of behavioral health services at a County level in California, with a focus on serious mental illness and addictions covering hospitals, clinics, jails, prisons, juvenile halls, foster care, veterans and homeless people (including services which have been contracted through extended networks of providers);
- Senior level collaboration across private, philanthropic, public, not-for-profit and academic sectors in multiple country contexts, including California. Working with stakeholders at international, national, state and local government levels, including engagement with significant policy and cultural influencers (with an impact on clinical as well as community-based practice).

The TA should focus on:

- Working with local stakeholders, including service users, in order to understand needs and to design empowering services that give control to each service user;
- Designing and deploying data systems to track and drive the performance of frontline services across health and human service systems, with a focus on mental health and addiction services as well as at-risk populations;
- Designing, procuring and overseeing performance- and outcomes-based contracts, relevant to the local context, including developing the reformed payment models for these contracts;
- Shifting services from grant-based or budget-reimbursed contracts to performance-and outcome-based models, managing the change to secure stakeholder buy-in, minimize disruption and maximize performance;
- Managing large networks of pan-sector contracted service providers, implementing performance management systems to drive outcomes/impact, intervening to address under-performance;
- Developing and delivering culturally-appropriate capacity building programs in contract design, procurement, and contract and performance management, for contracting bodies and for service providers;
- Developing and implementing human resource strategies to build skills, capacity and motivation to grow a workforce that is able to work at its best.

For further information or to provide feedback on the Report and/or our recommendations, please contact:

Richard Johnson,
Chief Executive Officer, the Healthy Brains Global Initiative
richard.johnson@hbgi.org

Dr Jonathan Sherin,
Chief Medical Officer, the Healthy Brains Global Initiative
jonathan.sherin@hbgi.org

www.hbgi.org

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

April 18, 2024
Richard Johnson, CEO
Healthy Brains Global Initiative

Letter sent via email

Dear Mr. Johnson:

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSP) during the Commission's May 23rd, 2024 meeting.

As you are aware, FSPs are a critical component of California's continuum of care for mental health, representing a "whatever it takes" partnership between the person being served and the service provider. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs remain underutilized and under supported. We seek your participation to highlight the vast potential to expand and fortify FSP service provision across the state, thus improving life outcomes for some of California's most vulnerable residents.

The meeting begins at 9:00 a.m. PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 30 minutes. Please summarize findings from your consultations with state and county stakeholders. With special attention to how county and state stakeholders:

- Define and measure success.
- Currently base their contracts for service delivery.
- Use data to track and report FSP performance.
- Currently execute contract and service management

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff. Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

April 18, 2024
Emily Melnick, Director
Third Sector

Letter sent via email

Dear Ms. Mielnik,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSP) during the Commission's May 23rd, 2024 meeting.

As you are aware, FSPs are a critical component of California's continuum of care for mental health, representing a "whatever it takes" partnership between the person being served and the service provider. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs remain underutilized and under supported. We seek your participation to highlight the vast potential to expand and fortify FSP service provision across the state, thus improving life outcomes for some of California's most vulnerable residents.

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- A summary of activities and main findings from your recent community engagement work with FSP community partners, service providers, and state agencies.
- Recommended next steps for better supporting FSPs.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff. Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

April 18, 2024
Jason Pace, Senior Associate Third Sector
Third Sector

Letter sent via email

Dear Mr. Pace,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSP) during the Commission's May 23rd, 2024 meeting.

As you are aware, FSPs are a critical component of California's continuum of care for mental health, representing a "whatever it takes" partnership between the person being served and the service provider. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs remain underutilized and under supported. We seek your participation to highlight the vast potential to expand and fortify FSP service provision across the state, thus improving life outcomes for some of California's most vulnerable residents.

The meeting begins at 9:00 a.m. PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 10 minutes. Please summarize findings from your consultation with state and county stakeholders. With special attention to how county and state stakeholders:

- A summary of activities and main findings from your recent community engagement work with FSP community partners, service providers, and state agencies.
- Recommended next steps for better supporting FSPs.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff. Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

April 18, 2024
Rose Waltz-Peters, Manager Third Sector
Third Sector

Letter sent via email

Dear Ms. Waltz-Peters,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSP) during the Commission's May 23rd, 2024 meeting.

As you are aware, FSPs are a critical component of California's continuum of care for mental health, representing a "whatever it takes" partnership between the person being served and the service provider. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs remain underutilized and under supported. We seek your participation to highlight the vast potential to expand and fortify FSP service provision across the state, thus improving life outcomes for some of California's most vulnerable residents.

The meeting begins at 9:00 a.m. PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 10 minutes. Please summarize findings from your consultation with state and county stakeholders. With special attention to how county and state stakeholders:

- A summary of activities and main findings from your recent community engagement work with FSP community partners, service providers, and state agencies.
- Recommended next steps for better supporting FSPs.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff. Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

May 8th, 2024
Susan Holt, LMFT
Behavioral Health Director, Fresno County

Dear Ms. Holt:

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSP) during the Commission's May 23rd, 2024 meeting.

As you know, FSPs are a critical component of California's continuum of care for mental health, representing a "whatever it takes" model to support, sustain, and improve the life outcomes of people with serious mental illness. When carried out fully and with efficacy, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and most importantly save lives. Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs remain underutilized and under supported. We seek your participation to bring to light the vast potential to expand and fortify FSP service provision across the state, thus diverting people away from jails, hospitals, and homelessness, and improving life outcomes for many of California's most vulnerable residents.

The meeting begins at 9:00 a.m. PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 10 minutes. Please share your insights on and experience with:

- The importance of Full Service Partnerships in the larger continuum of care
- The challenges presented by current legacy data collection systems
- The need for standardization of metric and outcomes

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff. Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

AGENDA ITEM 7

Action

May 23, 2024 Commission Meeting

Innovation Projects

Summary:
The Mental Health Services Oversight and Accountability Commission will hear a recommended approach to supporting counties through the transition to the BHSA and hear presentations from counties and consider approval of the innovation funding requests for the following projects:

1) Ventura: Early Psychosis Learning Health Care Network Collaborative
2) Fresno: Extension of the California Reducing Disparities Project
3) Mendocino: Native American Crisis Line
4) Fresno and Shasta: Multi County Collaborative - Psychiatric Advance Directive (PADs)

1) Ventura Early Psychosis Learning Health Care Network Collaborative:

Ventura County is requesting up to $10,137,474.63 of Innovation spending authority to join the Learning Health Care Network (LHCN) for existing Early Psychosis (EP) programs, a multi-county collaborative initially approved by the Commission on December 17, 2018.

Los Angeles, Orange, San Diego, Solano, Napa, Sonoma, Stanislaus, and Kern Counties were previously approved to contract with UC Davis Behavioral Health Center of Excellence to lead the Collaborative with support from One Mind and in partnerships with UC San Francisco, UC San Diego, and the University of Calgary. The LHCN used innovation funds to develop the infrastructure for the LHCN to increase the quality of services and improve outcomes. The LHCN developed, and now utilizes, a digital platform called Beehive to gather real-time data from clients and their family members in existing EP clinic settings and includes training and technical assistance to EP program providers.

Ventura County has seen increased demand and enrollment in their early psychosis program has more than doubled in size over the past two years. The County has struggled to meet the clinical demand. By joining the LHCN, the County hopes that the local support from the UC Davis team and other like counties will support them to grow their program with fidelity. The County believes that the LHCN outcome system is more streamlined and better for youth and will display current client progress rather than the annual evaluation that looks back on the previous year. This shift will allow the treatment team to make real-time decisions in collaboration with the client and their families.

The value of the full project will be examined through a statewide evaluation that will assess the impact of the LHCN on the EP care network and evaluate the effect of EP programs on consumer- and program-level outcomes.

Behavioral Health Services Act Alignment and Sustainability:
The County states that services provided within this project align with the Behavioral Health Services Act (BHSA) through the 35% allocated for behavioral health services and supports, specifically through the focus on early intervention. Following BHSA implementation, the County will utilize early intervention funds and federal reimbursement to sustain services.

The Community Program Planning Process:
The proposed innovation plan was posted by the county for public comment beginning January 26, 2024 and concluded on February 26, 2024. A behavioral health board hearing was conducted on February 26, 2024, and the plan was approved by their Board of Supervisors on April 23, 2024. Prior to the public comment period, Ventura County made a presentation to the Transitional Age Youth and the Youth and Family Behavioral Health Advisory Board subcommittee meetings and discussed the LHCN as a potential innovation project in the Annual Update, Fiscal Years 21-22 and 22-23.

Through a contract with the Commission from July-November 2018, the Contractor, UC Davis, worked to engage stakeholders statewide, including clients served by EP programs and their families, the leadership and clinical providers within EP programs, county, and state leadership, as well as community organizations in the development of this proposal. The LHCN follows a policy of 'nothing about us without us', with community stakeholder involvement at all levels of the project including through the formation of an Advisory Committee.

Commission staff shared this project with its six community partner contractors and the listserv on February 13, 2024, 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 May 3, 2024. No comments were received.

2)Fresno County California Reducing Disparities Project Extension:
Fresno County is requesting up to $2,953,244 of additional spending authority, for their innovation project: California Reducing Disparities Project Evolutions. This request stems from the changes under the Behavioral Health Services Act (BHSA). As part of their transition plan from the Mental Health Services Act (MHSA) to the BHSA, Fresno County seeks to extend this approved project to examine sustainability options for Community Defined Evidence Based Practices (CDEPs) by working with the existing CDEPs and through a new contract with Third Sector to provide technical assistance.

Behavioral Health Services Act Alignment and Sustainability:
Fresno County requests this extension of time and additional funding to add learning questions to identify strategies to sustain the identified CDEPs and to share the learnings statewide to support other CDEPs to adapt to the BHSA. The project will shift from a focus of sustainability via MHSA PEI funding, to exploring early intervention service options under the BHSA, beyond the BHSA, and through sustainable funding using federal financial participation (FFP) through Medi-Cal expansion provided under CalAIM.

The requested extension will conclude in April 2026, prior to the full BHSA implementation and will be fully funded with existing innovation dollars.

The Community Program Planning Process:
Fresno County met with the three local CRDPs/CDEPs about the sustainability concerns given the proposed and then approved BHSA. They discussed exploring opportunities for possible future funding through early intervention funds and FFP/Medi-Cal for their programing. The discussion with the providers also included bringing in technical assistance and interest in exploring existing service activities under CalAIM and other billable services. Providers were in support of receiving technical assistance and all providers agreed that sustainability planning and technical assistance should include capacity-building in areas such as data collection, billing processes, and use of electronic health records.

Fresno County also discussed the proposed extension at two MHSA Annual Update Community Planning forums in October and November 2023. In addition, they discussed the proposal at the virtual forum held in November 2023 (that meeting was recorded and has been available for review and feedback. To date, there have been 180 views). Pending Commission approval, Fresno County will bring this proposal to their Board of Supervisors.

Commission staff originally shared this project with its six stakeholder contractors and the listserv on February 28, 2024. The final version of this project was again shared with stakeholders on May 3, 2024. No comments were received.

3) Mendocino County Native American Crisis Line:
Mendocino County is requesting $1,001,395 for a peer run Native American Crisis Line. This project will establish a warm line to be administered by the Pinoleville Pomo Nation Tribe and will be tailored to the needs of the Native American Community. Pinoleville Pomo Nation has experience with providing services and connecting individuals to resources within this Community and has offered to take the lead with this project.

The County states warm lines are a step down from crisis lines and in this project, peers who are trained to respond to non-crisis situations will oversee this warm line. Peers will greet callers, listen, and offer support and referrals as needed. It is the hope that this warm line will eliminate barriers that are currently deterring Native Americans from reaching out for help or seeking resources. One of the learning goals the County has established is if the use of a

warm line, compared to a crisis line, invites more of the Native American Community to reach out due to the use of peers in this project. If there is distrust due to historical/current trauma, the Native American Community may be reluctant to reach out to a crisis line but may feel more comforted and less apprehensive if that warm line has a peer on the other line that they can relate to. The County recognizes there is an increasing need for peers and is just as important that the peers represent the demographic area in which they serve, ensuring a feeling of equity.

All staff will be required to complete Native American Cultural Competency training provided by Pinoleville Pomo Nation's Historical Trauma Informed Care Certification Program and a cultural consultant will be brought on to ensure proper training of staff. The warm line will be provided in English and Spanish; however, it is the hopes that it will be expanded to include Native American speakers as well.

Behavioral Health Services Act Alignment and Sustainability:
The County states that services provided within this project aligns within the 35% allocated for Behavioral Health Services and Supports, specifically targeting early intervention efforts. The Native Warm line will provide services with the goal of preventing mental illness and substance abuse disorders before they become severe and disabling by providing information, resources, triage, and referrals if needed, as well as peer to peer services for this underserved and at-risk population.

For this project, Mendocino is utilizing MHSA Innovation funding from previous years that will revert on July 1, 2024 and will be able to fund this project entirely. Upon completion of the project and depending on overall success, the County will decide if the project will continue without the use of innovation funding. After the project ends, the County will consider continued BHSA funding, grant funding, and Indian Health funding. The County has not considered utilizing other funding for this project.

The Community Program Planning Process:
This project was developed specifically with the Native American Community and will be administered by the Pinoleville Pomo Nation. Stakeholders in the county expressed concern over the mental health struggles experienced by the Native Community which has been exacerbated since the pandemic. Challenges leading to the development of this project exposed that individuals trying to receive mental health support were not receiving consistent messaging when trying to locate resources and community supports. Additionally, the community expressed frustration because some of the available materials and pamphlets containing resources are often outdated and services may no longer be available, causing more distress and frustration.

Upon receiving approval from the Commission, the County and the Pinoleville Pomo Nation will continue gathering information on the types of resources that would be needed in a

warm line, and feedback on how to best promote the use of the warm line so that stigma and apprehension around utilizing this warm line are not a factor when deciding to reach out.

The County has provided examples of meeting all MHSA General Standards of community collaboration, cultural competency, being client and family-driven, as well as being focused on wellness, recovery, and resilience (see pages 14-16).

Mendocino County held their 30-day public comment period between March 27, 2024 and April 27, 2024, followed by their Mental Health Board hearing on April 27, 2024. The County will seek Board of Supervisor approval pending Commission approval. The final project was submitted on May 1, 2024 following technical assistance from Commission staff beginning in February 2024.

Commission staff shared this project's initial plan with its stakeholder contractors and the Commission's listserv on April 18, 2024, and comments were directed to the County. The final version of this project's plan was shared with the Commission's community partners, and listserv on May 2, 2024. *No Comments were received in response to the Commission's request for feedback.*

4) Fresno and Shasta: Multi County Collaborative - Psychiatric Advance Directives

Fresno County is requesting $5,915,000 in Innovation funding to participate in Phase Two of the Psychiatric Advance Directives (PADs) multi-county collaborative. Shasta County is requesting $1,000,000 in Innovation funding to participate in Phase Two of the PADs multi-county collaborative.

The first cohort of the PADs project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City. The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training and a toolkit, as well as create a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and "live" use of PADs. At this time, Fresno and Shasta County are ready to pilot Phase Two; however, up to fifteen counties may join Phase Two by the end of the year.

Phase Two goals include the following (see pages 4-5 of project for details):

1. Engagement for new counties
2. Collaboration amongst stakeholders
3. Training and accessibility
4. Testing in a live environment

5. Evaluation
6. Transparency through www.padsCA.org.

Behavioral Health Services Act Alignment and Sustainability:
This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care (i.e. Veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, those with co-occurring substance use disorders).

The project also aligns with the Commission's Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery.

On April 23, 2024, The Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see page 4-5).*

Regarding sustainability, PADs has received support from current legislative action (AB2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the hope that it will secure ongoing funding from various agencies.

The Community Program Planning Process:
Fresno: In Phase Two, Fresno County is continuing to prioritize their focus on individuals experiencing homelessness and individuals who are at risk of, or are assigned to, conservatorships. The County states they are committed to addressing new legislative requirements of Proposition 1, Senate Bill 43, and CARE Court while providing recovery focused care and services to all those within the public behavioral health system.

This project was presented to community stakeholders and partners including the County's annual update, and the hosting of forums, in person and virtually. There were no areas of opposition that were raised for the County to join Phase Two of this collaborative.

The County's 30-day public comment period began on February 16, 2024, followed by a public health board hearing on March 20, 2024. The County received Board of Supervisor approval on May 2, 2024.

Shasta: Community feedback in the County has disclosed that individuals and their families feel helpless when interacting with law enforcement and the hospital system and the use of a

Psychiatric Advance Directive would empower individuals to be in control of their own decision making even when they may be incapacitated to make critical decisions.

Shasta hopes their involvement in this project will build capacity among first responders, peers, court system, providers, and consumers to assist in collaborative decision making. The County aims to also reduce recidivism while focusing on treatment and recovery.

During quarterly stakeholder meetings, board members, peers and first responders have all shown support for this project. Peer support specialists within the County are supportive of this project as they believe the accessibility of a standardized PAD would be helpful in helping individuals receiving the care and services they need in a more expeditious manager, especially in times of crisis.

Shasta County began their 30-day public comment period on April 19, 2024, followed their Behavioral Health Board Hearing on May 22, 2024. Shasta is expected to appear before their Board of Supervisors on June 25, 2024.

The final version of the PADs project was shared with the Commission's community partners and listserv on May 2, 2024. *In response to the Commission's request for feedback, a letter of support dated May 7, 2024 was received from The Steinberg Institute and has been included in Commissioner's packets.*

Enclosures (7): (1) Commission Community Engagement Process; (2) Presenter Biographies for Innovation Projects; (3) Ventura County Analysis, Early Psychosis Learning Health Care Network; (4) Fresno County Analysis, California Reducing Disparities Project Extension; (5) Mendocino County Analysis, Native American Crisis Line Collaboration; (6) Shasta County and Fresno County Joint Analysis for Psychiatric Advanced Directives (PADs); (7) Letter of Support for PADs from Steinberg Institute

Additional Materials (4): Links to the final Innovation projects are available on the Commission website at the following URLs:

Ventura – Early Psychosis Learning Health Care Network:
https://mhsoac.ca.gov/wp-content/uploads/Ventura_INN-Plan_Early-Psychosis-LHCN.pdf

Fresno – California Reducing Disparities Project Extension:
https://mhsoac.ca.gov/wp-content/uploads/Fresno_INN-Extension_CRDP-and-22-23-AU.pdf

Mendocino – Native American Crisis Line Collaboration:
https://mhsoac.ca.gov/wp-content/uploads/Mendocino_INN-Project-Plan_Native-Crisis-Line.pdf

Psychiatric Advanced Directives (PADs):
https://mhsoac.ca.gov/wp-content/uploads/Multi-County_INN-Project_PADs.pdf

Proposed Motions:

That the Commission approve Ventura County's Early Psychosis Learning Health Care Network Collaborative Innovation Project for up to $10,137,474.63.

That the Commission approve Fresno County's Extension of the California Reducing Disparities Innovation Project for up to $2,953,244.

That the Commission approve Mendocino County's Native American Crisis Line Innovation Project for up to $1,001,395.

That the Commission approve Fresno County's participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $5,915,000.

That the Commission approve Shasta County's participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $1,000,000.

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

Mental Health Services
Oversight & Accountability Commission

Ventura County Presenter Biography

Julie Glantz, LCSW

Julie has worked in the Mental Health Field for 30 years. She has served the Ventura County Community since 2006. She has experience with Youth & Families in residential and crisis services. While at VCBH she has provided services to some of the most vulnerable of the severe and persistent mentally ill Adult population. Currently, she is the Sr. Behavioral Health Manager for the Adult Division working closely with leadership to provider oversight of clinic and specialty services for TAY, Adult and Older Adult populations.

Professional Biography

Ahmad has worked in county behavioral health systems for over 15 years. Ahmad has been a Division Manger and the Equity Services Manager (ESM) for Fresno County Department of Behavioral Health (DBH) for over five years. Prior to that Ahmad worked as part of the leadership team in a small County Behavioral Health Department for over nine and a half years. Currently, Ahmad serves as the Division Manager where he and his team oversee the department's administration of the MHSA, health equity efforts, media and public engagement, prevention (including suicide and substance misuse), marketing, outreach and education among other duties. He has served and serves on a number of local and statewide workgroups and committees, including Children and Youth Behavioral Health Initiative (CYBHI) Evaluation Workgroup, CYBHI's Collaborative Leadership Work Group, CYBHI's Equity Task Force, the Department of Educations' Student Mental Health Policy Workgroup (SMHPW), California Pan Ethnic, Health Network (CPEHN)'s Community-Defined Evidence Practice Integration Advisory Group, California Department of Education's Student Mental Health Policy Workgroup, California Reducing Disparities Project Phase 3 Planning and Design Task Force, and other efforts. He was selected as a 2019 Mental Health Champion by the Steinberg Institute. Ahmad's educational background includes a Bachelor of Science in Criminology, a Master's in Business Administration, and completion of doctoral work in Organizational Development.

Biography for Mendocino

Rena Ford, Master of Sciences Earth and Planetary Sciences, Master of Library and Information Sciences, Staff Services Administrator, Behavioral Health and Recovery Services, Mendocino County. Rena has ten years of experience in public works with Mendocino County, and five years of experience working with the Mendocino County MHSA Unit.

Karen Lovato, Acting Deputy Director, Mendocino County Behavioral Health & Recovery Services and Public Health. Bachelor of Science in Psychology, Minor in Sociology. Twenty Three years in public mental health service, with several years in crisis response and supervision.

CONCEPTS FORWARD CONSULTING
From Concept to Completion

Biography for Kiran Sahota

Kiran Sahota has been working in the social services sector for nearly thirty years. Her role as a social worker led to many opportunities within county and non-profit employment, such as creating independent living skills and housing for transitional-aged youth, training law enforcement in crisis intervention and de-escalation, and building mental health innovation and prevention programs within a large county mental health plan. In 2020, Ms. Sahota retired from county mental health as a Senior Behavioral Health Manager and co-chair of the Statewide Mental Health Services Act Coordinators Committee.

Since retiring, Ms. Sahota has been working as the President of *Concepts Forward Consulting*. Through her consulting business, she is working with multiple California counties on a statewide Innovations impact project to test digital Psychiatric Advance Directives. She also provides counties with her strategic planning expertise and works as an External Quality Reviewer.

Throughout her career, Ms. Sahota has made significant contributions to community behavioral health programming. She has worked on quality impact improvement, program evaluation, and digital transformation with a global lens toward community service enhancement and systemic change. Her expertise includes innovative programming, digital transformation, strategic planning, law enforcement training, mental health advocacy, stakeholder engagement, and suicide prevention efforts. Ms. Sahota holds a master's degree in Clinical and Community Psychology.

STAFF ANALYSIS— VENTURA COUNTY

Innovation (INN) Project Name:	**Early Psychosis Learning Health Care Network**
Total INN Funding Requested:	**$10,137,474.63**
Duration of INN Project:	**4 Years**
MHSOAC consideration of INN Project:	**May 23, 2024**

Review History:

Approved by the County Board of Supervisors:	April 23, 2024
Mental Health Board Hearing:	February 26, 2024
Public Comment Period:	January 26, 2024- February 26, 2024
County submitted INN Project:	February 10, 2024
Date Project Shared with Stakeholders:	February 13, 2024 and May 3, 2024

Project Introduction:

Ventura County is requesting up to $10,137,474.63 of Innovation spending authority to join the Learning Health Care Network (LHCN) for existing Early Psychosis (EP) programs, a multi-county collaborative approved by the Commission on December 17, 2018.

Los Angeles, Orange, San Diego, Solano, Napa, Sonoma, Stanislaus, and Kern Counties were previously approved to contract with UC Davis Behavioral Health Center of Excellence to lead the Collaborative with support from One Mind and partnerships with UC San Francisco, UC San Diego, and the University of Calgary. The LHCN used innovation funds to develop the infrastructure for the LHCN to increase the quality of services and improve outcomes.

The LHCN developed, and now utilizes, an application called Beehive (a digital platform) to gather real-time data from clients and their family members in existing EP clinic settings and includes training and technical assistance to EP program providers.

The value of the full project will be examined through a statewide evaluation that will assess the impact of the LHCN on the EP care network and evaluate the effect of EP programs on consumer- and program-level outcomes.

Behavioral Health Services Act Alignment and Sustainability:

The County states that services provided within this project align with the Behavioral Health Services Act (BHSA) through the 35% allocated for behavioral health services and supports, specifically through the focus on early intervention. Following BHSA implementation, the County will utilize early intervention funds and federal reimbursement to sustain services.

What is the Problem?

The participating counties expressed that they would like to further improve outcomes for participants in EP programs while also reducing program costs. While almost half of the 58 counties in California have a dedicated EP program, there is lack of standardization and a lack of infrastructure to properly evaluate the fidelity to evidence-based practice and the effectiveness of these programs, making it impossible to disseminate best practices across programs. The demand for effective EP intervention programs combined with legislation requiring EP programs, funding to operate EP programs, and the need to implement quality improvement initiatives, led the Collaborative to develop the proposal to create the infrastructure for a sustainable LHCN for EP.

Ventura County Power Over Prodromal Psychosis (VCPOP) is an early intervention program that conducts community outreach and education to community members about early warning signs of psychosis and provides a four-year intervention program with services and supports including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups. The program has more than doubled in size over the past two years and the County has struggled to increase staffing to meet the clinical demand.

The need for additional services has also been observed through the program's focus on collaboration with families and other natural supports. During the Community Program Planning Process for this proposed project, it was requested to have more frequent parenting groups. Other services that have been in high demand are additional family therapy sessions, psychoeducational groups, and more in-home services.

What is the Innovation?

All counties and programs participating in this collaborative operate variations of the Coordinated Specialty Care (CSC) model, a world- wide, evidence–based treatment that has been the subject of at least two recent research projects in the United States (Azrin, Goldstein, Heinssen, 2016).

The LHCN created infrastructure in California to gather real-time data from clients and their family members in existing EP clinic settings that use the CSC model. Data is collected through a developed application via questionnaire on tablets. The collection of data via application and subsequent aggregation will allow programs to learn from each other and provide the infrastructure to position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US.

The LHCN proposal identifies three primary areas of focus:

1. Provide infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and "lessons learned" can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
2. Training and technical assistance to support EP program providers to have immediate access to relevant client-level data and anonymized data that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.
3. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

As a result of the project, Counties will be able to learn from each other and from leading experts in early psychosis treatment by using a common framework to improve processes and report on outcomes. Currently, counties have no easy way to share data from early psychosis programs and this LHCN is one solution providing a starting point to address the lack of shared data systems.

By joining the LHCN through an Innovation investment, Ventura County and the VCPOP team will have local support from UC Davis team and other like counties in establishing and growing their programs. The outcome system that the learning collaborative utilizes is more streamlined and better for youth/young adults who may be too ill to respond to the existing lengthier system. The outcome system that will be implemented though the collaborative will also display current client progress rather than the annual evaluation that looks back on the previous year. This shift will allow the treatment team to make real-time decisions in collaboration with the client and their families.

By joining the LHCN at a later stage than other participants, Ventura County is joining at a time where the application for data collection, Beehive, has already been developed and data collection is active and ongoing. As a benefit, Ventura County will be able to hit the ground running with data collection and immediately benefit from information from the large statewide dataset to inform clinical practice in their own clinics. In addition, the training approach to implementing Beehive in EP programs is well-established, has been refined through continuous feedback on what works and what doesn't, and now administer both synchronous and asynchronous training materials to programs so that all staff members have an opportunity to participate in the LHCN data collection.

In addition, the LHCN itself benefits from additional programs joining with more programs contributing data to the harmonized dataset. Ventura County is a diverse county with a well-established early intervention program with a large client base and will contribute unique information to the dataset.

Community Planning Process (see pages 108-109 of the County appendix)

Local Level

The proposed innovation plan was posted for public comment beginning January 26, 2024 and concluded on February 26, 2024. A behavioral health board hearing was conducted on February 26, 2024, and the plan was approved by their Board of Supervisors on April 23, 2024. Prior to the public comment period, Ventura County made a presentation to the Transitional Age Youth and the Youth and Family Behavioral Health Advisory Board subcommittee meetings on October 11th, 25th and December 20th, 2023. In addition, Ventura County discussed the LHCN as a potential innovation project in the Annual Update, Fiscal Years 21-22 and 22-23. On page 109 of the proposal, the County presents partner feedback in support of joining the LHCN to meet the need for EP services in the county.

State level

Through a contract with the Commission from July-November 2018, the Contractor, UC Davis, worked to engage stakeholders, including clients served by EP programs and their families, the leadership and clinical providers within EP programs, county, and state leadership, as well as community organizations in the development of this proposal.

The LHCN follows a policy of 'nothing about us without us', with community stakeholder involvement at all levels of the project including through the formation of an Advisory Committee. The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is currently co-led by a family advocate from Sacramento County.

The qualitative component of the proposed project will continue stakeholder engagement for the duration of the project. The Collaborative is relying on participating stakeholders to guide them on how to best serve the diverse communities of each EP program.

In addition, multiple letters of support were received in response to the original proposal. Please see pages 115-121 of full plan for more information.

Commission Level

Commission staff originally shared this project with its six community partner contractors and the listserv on February 13, 2024, 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 May 3, 2024.

Learning Objectives and Evaluation:

As part of the LHCN collaborative, Ventura County will follow the evaluation approach as laid out in the full LHCN plan. Key components of the evaluation plan are summarized below:

The LHCN will target individuals at increased risk or in the early stages of a psychotic disorder and estimates that more than 2,000 individuals will be served over the course of the project. Three approaches to the evaluation will be taken. These three approaches coalesce into a robust evaluation that meet the goals of the project and include: the utility of the LHCN for early psychosis programs, fidelity of early psychosis programs within counties, as well as the impact that early psychosis programs have on costs and individual outcomes—each approach is summarized below.

(1) *Utility of the LHCN for early psychosis programs*: This will be accomplished by utilizing information gathered from two samples of consumers and providers prior to LHCN implementation. The first sample of consumers will complete questionnaires at year 1 (pre-implementation period). Questionnaires will gather information on knowledge of illness, Perceived Effect of Use for the LHCN, Treatment Satisfaction, Treatment Alliance, and Comfort with Technology. Providers will also complete a questionnaire on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. The second sample of consumers and providers will complete these same questionnaires post-implementation at year 4.

(2) *Fidelity of early psychosis programs*: Using the revised First Episode Psychosis Services Fidelity Scale (FEPS-FS), the Collaborative will assess each clinic's adherence to evidence-based practices for first-episode psychosis services. Scores from the FEPS-FS will provide insights into components of each EP program that are associated with outcomes.

(3) *Impact of early psychosis programs on costs and outcomes*: Using three different data sources—program-level data, qualitative data, and county-level data—the impact that EP programming has on individual consumer outcomes as well as related costs will be examined (**see pgs.12-16 of Collaborative plan**).

a. Program-Level Data: upon consideration from stakeholder engagement discussions (**see qualitative data**), specific data elements will be selected and will stand as the foundation for the LHCN. Providers, consumers, and family members will identify measures of potential outcomes from the PhenX Early Psychosis Toolkit, the national Mental Health Block Grant, and others.
b. Qualitative Data: focus group interviews, and in-depth semi-structured interviews will be conducted with consumers, family members, and providers. With this method, feedback will be garnered at different stages of the project. This includes feedback related to identifying appropriate measures for use in the project. Additionally, these methods will allow evaluators to assess the feasibility of the implementation strategy and provide context to the interpretation of data analysis.

c. County-Level Data: consumer-level data relative to program service utilization, crisis/ED utilization, psychiatric hospitalization, and costs related to these utilization domains will be captured at the county-level.

These three evaluation approaches will be guided by several learning questions, **please see pages 10-12 in the Collaborative plan.** Data collection and analysis for the LHCN evaluation will take place in multiple stages throughout the project. UC Davis and partners will be responsible for data analysis and writing the final evaluation report.

The Budget

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	Contractor/ Evaluation	% for Evaluation	Sustainability Plan (Y/N)
Ventura	$10,137,474.63*	$10,237,946	$764,119	6.94%	Y
Previously approved:					
Los Angeles	$4,545,027	$1,575,310	$2,969,717	65.34%	Y
Orange	$2,499,120	$1,573,525	$925,595	37.04%	Y
San Diego	$1,127,389	$201,794	$925,595	82.10%	Y
Solano	$414,211	$291,399	$122,812	29.65%	Y
Napa	$258,480	$218,820	$39,660	15.34%	Y
Sonoma	$475,311	$230,347	$244,964	51.54%	Y
Stanislaus	$1,564,633	$1,140,585	$424,048	27.10%	Y
Kern	$1,632,257	$1,180,432	$451,825	27.68%	Y

Total	**$22,653,902.63**	**$16,650,158**	**$6,868,335**	**30.32%**

The costs for the LHCN and Evaluation component of the project are described below. Unlike the initial counties who established the LHCN, the costs for Ventura County to join the project are not proportional based on the size of their county. Instead, the costs outlined below are based on the added expenses needed to cover activities for one additional program to join the LHCN. Therefore, the budget narrative is different from the one in the main proposal. The other participating counties are paying a percentage of the contract with UC Davis based on the county size.

With the addition of Ventura County, UC Davis will receive $6,868,335 of Innovation funds to manage the project, hire consultants, sub-contractors and complete the LHCN evaluation. Ventura County will contribute a total of $764,119 to the LHCN evaluation and will retain $10,237,946 of approved Innovation funds (plus leveraged funding) for personnel and administration costs to augment the staffing needed to support participation in

the LHCN and to run the CSC program to fidelity. $300,000 of these funds are subject to reversion on July 1, 2024.

Personnel funded through Innovation include:

- 1 FTE Registered Nurse-Mental Health
- 4 FTE Behavioral Health Clinician IV
- 1 FTE Mental Health Associate
- 3 FTE Community Services Coord
- 1 FTE Office Assistant IV
- 1 FTE Behavioral Health Clinic Adm III
- 1 FTE Peer Specialist III
- 1 FTE Behavioral Health Manager

Other Funding*

Ventura County estimates utilizing $817,882.71 in reimbursement through Federal Financial Participation (FFP)/Medi-Cal and $46,404.80 of other funding, bringing the total cost of this project to $11,002,065.14.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations and is in alignment with the requirements of the BHSA.

Collaborative Update (see pages 26-29 of plan):

- LHCN continued to hold focus groups with consumers and providers to elicit feedback
    - To date, 34 interviews and 40 focus groups including 284 providers, service users, and family members have been completed across 15 EP programs. In the outcomes focus groups functioning, quality of life, recovery, and symptoms of psychosis were identified as key domains to assess in EP care.
    - Interviews with EP program providers and service users identified numerous benefits to the Beehive application and the adoption of measurement-based care in early psychosis settings. However, substantial variability in both in the feasibility of implementation, and the perception of the benefits and drawbacks of adopting such an approach was found.
- Progress of data collection in all EP programs
    - To date, 21 EPI-CAL (LHCN plus EPINET participation) clinics have registered 832 clients in the data collection and presentation application, Beehive.
    - Preliminary analyses of Beehive outcomes data began, including detailed analyses on client self-report symptoms, education, employment, and social activities and the relationship to quality of life, medication taking behavior, adverse childhood experiences, substance use, family functioning, and childhood poverty.
    - LHCN completed 20 fidelity assessments using the First Episode Psychosis Services – Fidelity Scale (FEPS-FS) version 1.1 and a pilot version of the Clinical High Risk for Psychosis Services – Fidelity Scale (CHRPS-FS).

- LHCN completed a preliminary multicounty integrated analysis for the retrospective period based on data provided by Los Angeles, Orange, and San Diego counties.
    - Preliminary results from this analysis show that youth enrolled in EP programs had a greater number of outpatient mental health visits and higher costs than a comparable group of youth who were receiving services in standard outpatient programs in both the first and second years following the initial diagnosis of psychosis.
    - Youth in EP programs had a lower probability of psychiatric inpatient admission than control group youth in the year following diagnosis. However, there was no significant difference in the number of inpatient days.
    - There were also no significant differences in psychiatric admissions or inpatient days in the second year following diagnosis.
- LHCN leadership has learned that a one-size-fits-all approach to implementation is not as effective as prioritizing input from programs to resolve issues rather than using a standalone, top-down approach.

STAFF ANALYSIS— Fresno County

Innovation (INN) Project Name:	**California Reducing Disparities Project Evolutions- EXTENSION**

Original Approval History:

Original Approval Date:	April 22, 2021
Original Amount Approved:	$2,400,000
Duration of INN Project:	Three (3) Years
Project Start Date:	November 30, 2021

Current Request:

Additional INN Funding Requested:	$2,953,244
Additional Time Requested:	Two (2) Years
MHSOAC consideration of INN Project:	May 23, 2024

Review History:

Approved by the County Board of Supervisors:	Pending Commission approval
Mental Health Board Hearing:	February 21, 2024
Public Comment Period:	December 29, 2023-Febriary 23, 2024
County submitted INN Project:	February 27, 2024
Date Project Shared with Stakeholders:	February 28, 2024 and May 3, 2024

Project Introduction:

Fresno County is requesting up to $2,953,244 of additional spending authority, for their innovation project: California Reducing Disparities Project Evolutions. This request stems from the changes under the Behavioral Health Services Act (BHSA). As part of their transition plan from the Mental Health Services Act (MHSA) to the BHSA, Fresno County seeks to extend this approved project to examine sustainability options for Community Defined Evidence Based Practices (CDEPs) by working with the existing CDEPs and through a new contract with Third Sector to provide technical assistance.

What is the Problem?

This project was originally approved by the Commission on April 22, 2021, for innovation funding up to the amount of $2,400,000 over three (3) years. This project was intended to support Fresno County and three of their community-based providers to identify how to transition three CDEP pilot projects from short-term, state funded programs to MHSA

Prevention and Early Intervention (PEI) funded programs. Under the current project, Fresno County sought to work with each of the three existing culturally responsive, community-defined projects, their participants, and community partners to identify a specific adaptation to each one of their programs. These community-identified adaptations were intended to integrate the projects into the system of care, without compromising the work and integrity of the programs, all while aligning the projects with sustainable funding.

Under the BHSA, PEI funds have been reallocated and counties can no longer rely on prevention funds as an ongoing source of funding. Because of this legislative change, Fresno County is requesting an extension of funding and time to continue working with the three CDEPs and, using the same process, identify how their services can better match early intervention criteria and/or secure revenues through California's payment reform (CalAIM) as a sustainable funding source to continue necessary services in the identified communities.

The three Fresno County CDEP projects working on this innovation project are:

Sweet Potato Project - This is a program that utilizes Fresno's rich agricultural infrastructure and combines that with entrepreneurship to provide education about urban and sustainable agriculture. Students aged 11-15 in the cohort (15 at a time) participate in entrepreneurship, business skills and training to learn how to develop their products and sell them. During the off season, the students enter a second phase where they harvest and develop business plans and sell their product.

Hmong Helping Hands - The program implemented by the Fresno Center (formerly the Fresno Center for New Americans) provides an array of services intended to engage underserved older adult Hmong community members in a culturally responsive manner, including through education and wellness activities.

Atención Plena and Pláticas - Operated by Integral Community Solutions Institute (ICSI), this program supports community health and engagement through advocacy and systems change that promotes whole person wellness for Latino/x youth. The project adapts things such as expression activities, talking circles, and mindfulness practices that are rendered in a youth-centric Latino/x focused manner for behavioral health engagement and early non-clinical prevention and engagement activities.

These three programs have worked to establish services that are embraced by their communities. **There is an ongoing need to understand how to bring these programs into Fresno County's existing system of care in a financially sustainable manner, without changing what has made the programs successful with those underserved and inappropriately served African Americans, Latino/x, and Hmong communities.**

While these programs were previously funded by the State Department of Public Health using short-term MHSA dollars, they were not connected to, or included in, the local behavioral health system of care. When Fresno County proposed this project in 2021, they sought to align

the programs with PEI funding and had no way to know that PEI funds would no longer be available following the legislative changes under the BHSA. Although funding allocations have changed, the programs remain critical to meet the need in Fresno County. Fresno County seeks to continue these programs, which requires new learning questions, additional time, and an increased budget.

How this Innovation project addresses this problem:
Fresno County requests this extension of time and additional funding to add learning questions to identify strategies to sustain the identified CDEPs and to share the learnings statewide to support other CDEPs to adapt to the BHSA. The project will shift from a focus of sustainability via MHSA PEI funding, to exploring early intervention service options under the BHSA, beyond the BHSA, and through sustainable funding using federal financial participation (FFP) through Medi-Cal expansion provided under CalAIM.

A key component of this extension is a focus on additional capacity building to improve data collection, data reporting, and utilization of the electronic health record by the CDEP programs. **The County will partner with Third Sector to provide specific technical assistance (TA) to the three CDEPs.** As Third Sector is currently a California Department of Health Care Services Providing Access and Transforming Health (PATH) TA Marketplace provider, they can use those existing resources, expertise, and opportunities to support the three CDEPs in exploring how this new infrastructure can support their programs.

The County's partnership with Third Sector increases the organizational capacity and adds needed experience to support efforts to address the additional learning questions. Third Sector will provide expertise through TA on the Enhanced Care Management and Community Supports. Third Sector will support the examination of the CDEP programs, their design and where those programs may be able to either access other funding through FFP and/or identify adaptions which may support their evolution into effective early intervention services that can draw down FFP and better align with future BHSA funding.

Currently, nearly all programs operating as CDEPs are non-specialty mental health programs and not in a position to be able to draw down FFP. None of the program designs in Fresno County align with billable services and require significant adaptions to be able to draw down FFP/Medi-Cal or to be able to emerge as specialty mental health providers with culturally responsive care as suggested in the BHSA.

Community Planning Process (see pages 7-9 in County plan)

Local Level
Fresno County met with the three CRDPs/CDEPs about the sustainability concerns given the proposed and then approved BHSA. They discussed exploring opportunities for possible future funding through early intervention funds and FFP/Medi-Cal for their programing. The discussion with the providers also included bringing in technical assistance and interest in exploring existing service activities under CalAIM and other billable services. Providers were

in support of receiving technical assistance and all providers agreed that sustainability planning and technical assistance should include capacity-building in areas such as data collection, billing processes, and use of electronic health records.

Fresno County also discussed the proposed extension at two MHSA Annual Update Community Planning forums in October and November 2023. In addition, they discussed the proposal at the virtual forum held in November 2023 (that meeting was recorded and has been available for review and feedback. To date, there have been 180 views).

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on February 28, 2024. The final version of this project was again shared with stakeholders on May 3, 2024.

At the date of this writing, no comments were received in response to Commission sharing the plan. Any letters received after sharing the final version will be included as a handout.

Learning Objectives and Evaluation (see pages 5-6 of County plan)

With the extension, the plan seeks to address the following learning questions:

1. Can any of the current CDEPs, with technical assistance, transition into early intervention programs, or programs which can bill Medi-Cal for its work as sought in the BHSA?
2. Can the County develop a workflow or model that may be used to support sustainability planning for other CDEPs projects around the state, and future CDEPs?

Budget

Funding Source	Year-1	Year-2	**TOTAL**
Innovation Funds	$1,401,622	$1,551,622	$ 2,953,244
3 Year Budget	Year-1	Year-2	**TOTAL**
Administration	$ 10,000	$ 10,000	$ 20,000
Technical Assistance (Third Sector)	$ 275,000	$ 275,000	$ 550,000
Vendor Costs	$ 1,026,622	$ 1,176,622	$ 2,203,244
Evaluation	$ 90,000	$ 90,000	$ 180,000
TOTAL:	$ 1,401,622	$ 1,551,622	**$ 2,953,244**

The County is requesting authorization to spend up to $2,953,244 in MHSA Innovation funding for this project over a period of two additional years.

- Personnel costs total $0 as most of the innovation budget will be applied to the project through vendors.

- Vendor costs total $2,190,963 to fund three programs at current operating costs for three years:
    - Sweet Potato- The projected Two-Year amount shall not exceed $697,116.
    - Hmong Helping Hands- The projected Two-Year amount shall not exceed $803,218.
    - Integral Community Solutions Institute- The projected Two-Year amount shall not exceed $702,910.
- Technical Assistance provided by Third Sector totals $550,000.
- Administrative costs total $20,000 and include indirect costs.
- Evaluation costs total $180,000 (6% of total budget).

Of note, the requested extension will conclude in April 2026, prior to the full BHSA implementation and will be fully funded with existing innovation dollars. This project includes funds that are subject to reversion on July 1, 2024.

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

STAFF ANALYSIS – MENDOCINO COUNTY

Innovation (INN) Project Name:	**Native Crisis Line – A Partnership between Pinoleville Pomo Nation and Mendocino County**
Total INN Funding Requested:	**$1,001,395**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**May 23, 2024**

Review History:

Approved by the County Board of Supervisors:	Pending Commission Approval
Mental Health Board Hearing:	April 27, 2024
Public Comment Period:	March 27, 2024-April 27, 2024
County submitted INN Project:	May 1, 2024
Date Project Shared with Stakeholders:	April 18, 2024 and May 2, 2024

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase access to mental health services to underserved groups and to promote interagency and community collaboration related to Mental Health Services or supports or outcomes.*

This Proposed Project meets INN criteria *making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

Project Introduction:

The County would like to contract with Pinoleville Pomo Nation to develop and staff a Native warm line tailored specifically to the needs of Native American communities within Mendocino County. The warm line will utilize peers with lived experience and will reflect the cultural needs of the Native American community.

Behavioral Health Services Act Alignment and Sustainability:

The County states that services provided within this project aligns within the 35% allocated for Behavioral Health Services and Supports, specifically targeting early intervention efforts. The Native Warm line will provide services with the goal of preventing mental illness and substance abuse disorders before they become severe and disabling by providing information, resources, triage, and referrals if needed, as well as peer to peer services for this underserved and at-risk population.

For this project, Mendocino is utilizing MHSA Innovation Funding from previous years that will revert on July 1, 2024 and will be able to fund this project entirely. Upon completion of the project and depending on overall success, the County will decide if the project will continue without the use of innovation funding. After the project ends, the County will consider continued BHSA funding, grant funding, and Indian Health funding. The County has not considered utilizing other funding for this project.

What is the Problem:

Although Mendocino County is small and rural, it is home to many federally and non-federally recognized Native American Tribes. Due to the current and historic trauma Native Americans face, it is often difficult for this population to reach out and seek help with mental health challenges.

The creation of this project came as a result of community members voicing the lack of a safe space where Native Americans can call without feeling stigmatized, or feeling like they are unable to access resources that are respective of their culture.

Suicide has an extremely high prevalence rate among the Native American Community with suicide being the 8th leading cause of death, and for individuals between the ages of 5-25, that number increases to suicide being the 2nd leading cause of death. Additionally, suicide rates within the County are typically double the state rate and the County would like to partner with Pinoleville Pomo Nation Tribe to bring mental health resources to this underserved community.

The County reports the following shocking statistic: ***At least five Native Americans died by suicide and at least nine attempted suicide during the development of this proposal.***

How this Innovation project addresses this problem:

This project will establish a warm line to be administered by the Pinoleville Pomo Nation Tribe and will be tailored to the needs of the Native American Community. Pinoleville Pomo Nation

has experience with providing services and connecting individuals to resources within this Community and has offered to take the lead with this project.

The County states warm lines are a step down from crisis lines and in this project, peers who are trained to respond to non-crisis situations will oversee this warm line. Peers will greet callers, listen, and offer support and referrals as needed. It is the hope that this warm line will eliminate barriers that are currently deterring Native Americans from reaching out for help or seeking resources. One of the learning goals the County has established is if the use of a warm line, compared to a crisis line, invites more of the Native American Community to reach out due to the use of peers in this project. If there is distrust due to historical/current trauma, the Native American Community may be reluctant to reach out to a crisis line but may feel more comforted and less apprehensive if that warm line has a peer on the other line that they can relate to. The County recognizes there is an increasing need for peers and is just as important that the peers represent the demographic area in which they serve, ensuring a feeling of equity.

All staff will be required to complete Native American Cultural Competency training provided by Pinoleville Pomo Nation's Historical Trauma Informed Care Certification Program and a cultural consultant will be brought on to ensure proper training of staff. The warm line will be provided in English and Spanish; however, it is the hopes that it will be expanded to include Native American speakers as well.

The Community Program Planning Process (see pages 14-16):

Local Level

This project was developed specifically with the Native American Community and will be administered by the Pinoleville Pomo Nation. Stakeholders expressed a concern over the mental health struggles experienced by the Native Community which has been exacerbated since the pandemic. Challenges leading to the development of this project exposed that individuals trying to receive mental health support were not receiving consistent messaging when trying to locate resources and community supports. Additionally, the community expressed frustration because some of the available materials and pamphlets containing resources are often outdated and services may no longer be available, causing more distress and frustration.

Upon receiving approval from The Commission, the County and the Pinoleville Pomo Nation will begin to conduct meetings and surveys with the Native American population to inquire into the nuts and bolts of what this project may offer, including but not limited to gathering information regarding the types of resources that would be needed in a warm line, gathering feedback on how to best promote the use of the warm line so that stigma and apprehension around utilizing this warm line are not a factor when deciding to reach out.

The County has provided examples of meeting all MHSA General Standards of community collaboration, cultural competency, being client and family-driven, as well as being focused on wellness, recovery and resilience (see pages 14-16).

Mendocino County references a prior approved innovation project that was completed back in 2022 that focused on a crisis/drop in respite center. Although the learning goals of that project were different, the project highlighted the overarching need for services tailored specifically for the Native American Community, recognizing the importance of culturally relevant services and activities. It was important for those lessons to be incorporated in the development of this project. The County also references other existing warm lines and hotlines and how this project differs from those (see pages 8-9).

Mendocino County held their 30-day public comment period between March 27, 2024 and April 27, 2024, followed by their Mental Health Board hearing on April 27, 2024. The County will seek Board of Supervisor approval pending Commission approval, likely May or June 2024. The final project was submitted on May 1, 2024 following technical assistance from Commission staff beginning in February 2024.

Commission Level

Commission staff shared this project's initial plan with its stakeholder contractors and the Commission's listserv on April 18, 2024, and comments were directed to the County. The final version of this project's plan was shared with the Commission's community partners, and listserv on May 2, 2024.

No comments were received in response to the Commission's request for feedback.

Learning Objectives and Evaluation (see pages 9-13):

The proposed innovation plan aims to develop a Native American warm line to serve Native Americans ensuring staff are culturally responsive to the communities they are serving and are trained in meeting the needs of Native Americans struggling with mental health. The County hopes to serve over 1,200 individuals annually through this warm line by improving access for this underserved community with the overarching goal of addressing mental health needs and reducing the high rates of suicide that is prevalent within the Native American Community.

The County has identified the following four (4) main learning questions:

1) Does creating a local, Native American based warm line overcome barriers to calling warm lines (as determined by comparing data to other warm lines and Native focused hotlines)
2) Does the local community require peer ethnicity and peer lived experience to overcome barriers to calling warm lines?

3) Are there specific tip sheets/call center guidelines or best practices that can be developed from the learning lessons of the warm line that can be shared? Perhaps an adaptation of the state tip sheet for local concerns.
4) Are there specific triggers/retraumatizing practices that should be avoided by warm lines (i.e., involving law enforcement, removal of someone from tribal land by force/5150, etc.)

The County will utilize various tools and strategies to measure learnings from the questions established:

- Comparison of demographic from those who utilize the Native warm line to those who utilize the County's Crisis line
- Identifying a list of trauma triggers that have created barriers or challenges for the Native American Community when reaching out for mental health needs and resources
- Creation of a community defined best practice or "tip sheet" that has been vetted through the Native American Community that can be utilized for this project and shared with other call centers to overcome stigma and avoid words that may trigger additional trauma

The County has also outlined project goals along with methods to measure success of each of the specified goals (see pages 10-13).

Although the County has developed this project in partnership with the Pinoleville Pomo Nation who will implement and run this project, the County will hire an external evaluator to ensure the use of the warm line data has been collected, analyzed, and incorporated into the evaluation of this project.

Pinoleville Pomo Nation will work with the selected contractor to ensure all elements of the evaluation are culturally sensitive and will avoid terminology that is seen as insensitive or triggering.

The Budget (see pages 22-29):

4 Year Budget	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
Personnel	$ 58,240.00	$ 105,248.00	$ 137,072.00	$ 141,856.00	$ 442,416.00
Operating Costs (Direct and Indirect)	$ 147,971.00	$ 117,535.00	$ 95,070.00	$ 90,286.00	$ 450,862.00
Non-recurring costs	$ 7,306.00	$ 811.00	$ -	$ -	$ 8,117.00
Other expenditures	$ 25,000.00	$ 25,000.00	$ 25,000.00	$ 25,000.00	$ 100,000.00
Total Project Cost	**$ 238,517.00**	**$ 248,594.00**	**$ 257,142.00**	**$ 257,142.00**	**$ 1,001,395.00**
Total Innovation Request	**$ 238,517.00**	**$ 248,594.00**	**$ 257,142.00**	**$ 257,142.00**	**$ 1,001,395.00**

Mendocino County is requesting authorization to spend up to $1,001,395 in MHSA Innovation funding for this project over a period of four years. ***Note: approximately $574,880 of this project is subject to reversion by the end of this fiscal year.***

Personnel costs total $442,416 (44.2% of the total project) and will cover the following costs associated with the hiring of a Lead Warm Line Coordinator, a Warm Line Coordinator, and a Trainee.

Operating expenditures consist of direct and indirect costs totaling $450,862 (45% of total project) that will cover the daily operations for this project including but not limited to: personnel benefits, building rental and utilities, technology support and maintenance, office supplies, travel and training, gas utilized for traveling to meet with tribal communities for meetings and surveys. **Consultant costs total $91,039** and are absorbed within the operating expenditures, accounting for 9.1% of total project cost.

Non-recurring costs total $8,117 (0.81% of total project) and will cover costs associated with the office space (office desks, chairs, computer and laptops).

County costs total $100,000 for services rendered over the length of the project.

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations**; however**, if Innovation Project is approved, the County must receive and inform the MHSOAC of this certification of approval from the Mendocino County Board of Supervisors before any Innovation Funds can be spent.

Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding their sustainability plans.

STAFF ANALYSIS - MULTI-COUNTY COLLABORATIVE

Innovation (INN) Project Name: **Psychiatric Advance Directives – Phase 2**

MHSOAC consideration of INN Project: **May 23, 2024**

Review History:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing
Fresno	$5,915,000	4 Years	2/16/2024-3/16/2024	3/20/2024
Shasta	$1,000,000	4 Years	4/19/2024-5/19/2024	5/22/2024
TOTAL:	**$ 6,915,000**			

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase access to mental health services to underserved groups, promote interagency and community collaboration related to Mental Health Services, supports or outcomes, and increases the quality of mental health services, including measured outcomes.*

This Proposed Project meets INN criteria *introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.*

Project Introduction:

Fresno and Shasta County are seeking approval to use innovation funds to perform live testing and evaluation of the use of a digital Psychiatric Advance Directive utilizing the web-based platform. The overall goals of Phase Two will focus on engagement, collaboration, training, testing, evaluation, and transparency.

Psychiatric Advance Directives (PADs) are used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental

health condition. They generally are used to support individuals at risk of a mental health crisis where decision-making capacity can be impaired. PADs allow an individual's wishes and priorities to inform mental health treatment. Like their general health care counterpart, a PAD can also allow an individual to designate proxy decision-makers to act on their behalf in the event the individual loses capacity to make informed decisions.

PADs Phase One Background:

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training, a toolkit, as well as the creation of a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Phase One will culminate with the following goals being achieved:

- Standardized PAD template language for incorporation into an online and interactive cloud-based webpage, created in partnership with Peers and first responders
- Creation of a PADs facilitator training curriculum that will utilize a training-the trainer model for facilitation
- Creation of easily reproducible technology that can be used across California while maintaining sustainability
- Legislative and policy advocacy to create a legal structure to recognize PADs
- Evaluation of the development and adoption of PADs, the understanding of PADs, and the user-friendliness of PADs with measured outcomes

The goals for Phase Two are to take achievements from Phase One and test them in a live environment following training on the use and completion of PADs occurs.

Behavioral Health Services Act Alignment and Sustainability:

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care (Veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, those with co-occurring substance use disorders).

The project also aligns with the current Behavioral Health Services Oversight and Accountability Commission (BHSOAC) Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery.

On April 23, 2024, The Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see page 4-5).*

Regarding sustainability, PADs has received support from current legislative action (AB2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the overarching goal of securing ongoing funding from various agencies.

What is the Problem:

As outlined in Phase One of the PADs project, there is widespread support for the use of PADs to empower people to participate in their care, even during times of limited decision-making capacity. PADs can improve the quality of the caregiver-client relationship and improve health care outcomes. The Joint Commission on the Accreditation of Healthcare Organizations recognizes the value of psychiatric advance directives for treatment decisions when an individual is unable to make decisions for themselves (JCAHO, Revised Standard CTS.01.04.01).

While psychiatric advance directives were first put utilized in the United States in the 1990s, and have widespread support, research suggests their use is limited by lack of awareness, and challenges with implementation.

Although 27 states have passed laws recognizing PADs, most PADs are incorporated with the main emphasis on physical health. Adding to this is that there is not a standardized template for individuals, or their support systems, to access it when they might need it the most.

With the increasing rates of mental illness and high rates of recidivism, steps need to be taken so that directives are in in place in the event a person experiences a psychiatric episode.

Phase One explored the utility of PADs as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement. Phase Two will focus on the effectiveness of a PAD with training and live testing.

Innovation project overview:

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and "live" use of PADs. At this time, Fresno and Shasta County are ready to pilot Phase Two; however, up to fifteen counties may join Phase Two by the end of this calendar year.

Phase Two goals include the following (see pages 4-5 for details):

1. Engagement for new counties joining the project. Counties will work with first responders, behavioral health departments, courts, local NAMI chapter and peer organizations to better understand PADs and how to successfully utilize a PAD.
2. Collaboration amongst stakeholders will continue surrounding legislative efforts and to inform and enhance the use and access of a standalone PAD when tested in a "live" environment. Some of the groups that will partner include but are not limited to county staff, peer support specialists, Painted Brain, Cal Voices, Disability Rights of California, local NAMI chapters, California Professional Firefighters, California Sheriff's Association, California Hospital Association, Department of Justice, Patient Right's attorneys to name a few.
3. Training will be the main component within this project and the use and accessibility of a PAD will be closely monitored throughout the project. Training modules will be provided for first responders, crisis intervention teams, CARE Courts for judicial staff, Peer training for Peer Support Specialists and peer supports within the court system, and counties who have identified their own priority population.
4. Testing will occur after training has been provided. The testing phase will occur in a live environment to determine the ease of use, number of PADs that have been completed, and the disposition of law enforcement and hospitals to assess if there was a reduction in the number of 5150s requiring hospitalization due to the availability and use of a PAD.
5. Evaluation of Phase Two will continue from Phase One; however, emphasis will be on the intersectionality of the use of a PAD combined with the technology platform. Evaluation will include data obtained through interviews and observation and will meet all Institutional Review Board (IRB) requirements.
6. Transparency will be made available as Phase Two progresses on the project's website: www.padsCA.org.

The purpose of Phase Two will be to perform in-depth training, testing and evaluation of the tasks completed during Phase One.

Discussion of County Specific Regulatory Requirements

Fresno

In Phase Two, Fresno County is continuing to prioritize their focus on individuals experiencing homelessness and individuals who are at risk of, or are assigned to, conservatorship. The County states they are committed to addressing new legislative requirements that focus on these same populations (Proposition 1, Senate Bill 43, CARE Court) while providing recovery focused care and services to all those within the public behavioral health system.

This project was presented to community stakeholders and partners within the County's annual update and hosted in-person and virtual forums. There were no areas of opposition that were raised for the County to join Phase Two of this collaborative.

Locally, Fresno Behavioral Health plans to train approximately 500 County employees and contracted providers in the facilitation and administration of PADs to empower individuals across their system of care.

The County's 30-day public comment period began on February 16, 2024, followed by a public health board hearing on March 20, 2024. The County received Board of Supervisor approval on May 2, 2024.

Fresno proposes to spend $5,915,000 in Innovation funding towards this multi-county collaborative.

Shasta

Community feedback in the County has disclosed that individuals and their families feel helpless when interacting with law enforcement and the hospital system and the use of a PAD would empower individuals to be in control of their own decision making even when they may be incapacitated to make critical decisions.

Shasta hopes their involvement in this project will build capacity among first responders, peers, court system, providers, and consumers to assist in collaborative decision making. The County aims to also reduce recidivism while focusing on treatment and recovery.

During quarterly stakeholder meetings, board members, peers and first responders have all shown support for this project. Peer support specialists within the County are supportive of this project as they believe the accessibility of a standardized PAD would be helpful in helping individuals receiving the care and services they need in a more expeditious manager, especially in times of crisis.

Shasta County began their 30-day public comment period on April 19, 2024, followed their Behavioral Health Board Hearing on May 22, 2024. Shasta is expected to appear before their Board of Supervisors on June 25, 2024.

Shasta County proposes to spend up to $1,000,000 in Innovation funding towards this multi-county collaborative.

Commission Level

The final version of this project was shared with the Commission's community partners and listserv on May 2, 2024.

In response to the Commission's request for feedback, a letter of support dated May 7, 2024 was received from The Steinberg Institute and has been included in Commissioner's packets.

Learning Objectives and Evaluation (see pages 22-26):

Burton Blatt Institute will continue their work on this project and be the primary subcontractor, working in collaboration with other subcontractors, to perform the evaluation based on the established learning questions during this testing and implementation phase.

The following **individual and service-level** questions have been identified as follows:

(1) In the opinion of PADs county managers, did Phase 2 counties achieve the outcomes they specified in their work plans to test and implement the PADs web-based platform with their priority peer populations and community-based stakeholders?

(2) In the opinion of mental health legislative advocates, did PADs and its web-based platform address the county's goals for mental health treatment and recovery and for reducing the frequency of involuntary hospitalizations?

(3) In the opinion of peers, did accessing and using the PADs web-based platform positively affect their lives over the three-year evaluation period?

- a. Did they experience increased feelings of empowerment, self-direction, and hope for the future by creating a web-based PAD?
- b. Did they have better experiences with law enforcement, first responders, hospitals, and others when their web-based PAD was accessed and used when they were in crisis?
- c. Did using a web-based PAD decrease the length of time when they were in crises and could not make their own decisions?
- d. Did the use of a web-based PAD decrease the frequency of involuntary psychiatric commitments?
- e. Did they feel that having a web-based PAD improved the quality of crisis response services they receive from their mental health, homelessness, criminal justice, and other agencies who work with them?
- f. Was their crisis support system, including peers, family members, and stakeholder agency staff, strengthened by their use of a web-based PAD?

(4) In the opinion of community agency stakeholders, how did access and use of the PADs web-based platform positively affect how law enforcement, first responders,

hospitals, and others serve peers when they are in crises over the three-year evaluation period?

a. Did orientation and training on PADs and its web-based platform improve their understanding, acceptance, and capacity to access and use web-based PADs on behalf of peers when they are in crisis situations?
b. Did they feel that accessing and using a peer's web-based platform improved their de-escalation, treatment, and support experiences when peers are in crisis situations?
c. Was the PADs web-based platform sufficiently customized to address the capacity and technology infrastructure of law enforcement, first responders, medical and mental health care providers, and other stakeholders including Care Courts in accessing and using a peer's PAD?
d. Did the PADs web-based platform affect the ways that Care Courts, law enforcement, first responders, medical and mental health care providers, and other stakeholders interact with and support peers in mental health crisis situations?
e. Was access and use of the PADs web-based platform integrated into the services that mental health agencies, including Full Services Partnerships, and community stakeholders provide to peers in crisis situations?
f. Were there indicators that access, and use of the PADs web-based platform could be sustainable and under what conditions?

The following **systems level** questions have been identified as follows:

1) Were Phase 2 counties successful in aligning services, partnerships, funding, and systems in testing and demonstrating the effectiveness of the PADs web-based platform, including its acceptance and use by Care Courts?
2) Did the knowledge and experiences of implementing the PADs web-based platform in Phase 1 counties inform and improve the design, marketing, and use of the PADs web-based platform among Phase 2 counties?
3) Were precepts of peer inclusion and methods of incorporating peer perspectives established during Phase 1 relevant and effective in accessing and using the PADs web-based platform by Phase 2 counties' priority populations?
4) Were Phase 2 counties able to establish a process and plan for sustaining and replicating the access and use of the PADs web-based platform by their priority populations, and community stakeholders?

For specific evaluation methods, please see page 22 and pages 24-26.

The Budget (see Appendix pages 30-36):

Fresno and Shasta county are collectively contributing $6,915,000 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for four years.

Fresno County - seeking $5,915,000 total in innovation dollars

- Fresno is contributing $3,000,000 (51% of County-allocated budget) towards consultant and evaluation costs
- County costs total $2,915,000 to cover training and technical assistance, administrative costs, marketing supplies, equipment costs, and costs associated with travel and mileage.

Shasta County - seeking $1,000,000 total in innovation dollars

- Shasta is contributing $240,000 (24% of County-allocated budget) towards consultant and evaluation costs
- County costs total $760,000 to cover personnel costs, travel costs, incentives for peers and outreach materials, office supplies and technology needs
- ***Note: Shasta will have a total of $422,579 that will revert as of July 1, 2024***

This project will partner with the following contractors for the implementation, training, testing and evaluation of this project (see page 28 for listed Contractors in this project):

- Concepts Forward Consulting – will be the assigned Lead Project Manager and will provide case management, full project oversight, financial oversight of sub-contractors and will work closely with Commission staff
- Alpha Omega Translation – will over translation and interpretation services
- Burton Blatt Institute will perform the evaluation of this phase of the project
- Idea Engineering – will offer strategic consultation and creative direction as a full-service marketing agency (i.e. video direction and production, graphic design, translation, art production and coordination)
- Painted Brain - Peer Organization selected by counties who participated in Phase One to by providing input at stakeholder meetings representing the peer voice. Painted Brain will be instrumental in utilizing peers for this project, including outreach, education, peer representation, legislative advocacy, and training in the use of PADs platform.
- Chorus Innovations, Inc - this consultant will continue from building the secure, private, and voluntary platform where individuals can store their PADs to now testing the live platform

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations**; however**, if Innovation Project is approved, Shasta County must receive and inform the MHSOAC of this certification of approval before any Innovation Funds can be spent.

Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding their sustainability plans.

May 7, 2024

Mara Madrigal-Weiss
Chair, Mental Health Oversight
& Accountability Commission
1812 9th Street
Sacramento, CA 95811

Re: Innovation Plan for Fresno and Shasta Counties to join PHASE 2 of the Psychiatric Advanced Directives (PADs) Multi-County Collaborative – Support

Dear Chair Madrigal-Weiss:

On behalf of the Steinberg Institute, I am writing to express our enthusiastic support for the proposed Innovation Plan for Fresno and Shasta Counties to join PHASE 2 of the Psychiatric Advanced Directives (PADs) Multi-County Collaborative. This plan will elevate community and care worker awareness of PADs, giving more agency to people living with behavioral health conditions, particularly in moments of crisis. The Steinberg Institute is an independent nonprofit public policy institute dedicated to transforming California's mental health and substance use care systems through education, advocacy, accountability, and inspired leadership. Our Vision 2030 is an ambitious set of goals for reducing systems involvement for people with behavioral health conditions. We believe PADs will reduce system involvement by empowering individuals in their decision-making which will lead to improved long-term outcomes and autonomy.

Incorporating PADs into a user-friendly, cloud-based platform will make it easier for care providers and first responders to access them in the field, ensuring that people receive the care decisions that meet their needs. The development of a standardized PAD template and a comprehensive training curriculum is instrumental in bolstering the capabilities of peers, first responders, and other stakeholders.

The proposed funds will facilitate critical engagements such as training for county agencies, first responders, judicial staff, and peer support specialists. We also support the focus on priority populations including justice-involved individuals, those in crisis residential programs, and transitional-aged youth, as these groups often face significant barriers to accessing effective mental health care. Additionally, Phase 2 includes partner organizations with a proven track record of integrated community involvement that is essential for the success of mental health innovations.

Furthermore, the ongoing evaluation will provide vital data to inform continuous improvements and ensure the project's alignment with the highest care and efficiency standards.

In conclusion, the Steinberg Institute fully supports the PADs Multi-County Collaborative Phase 2 proposal for Fresno and Shasta Counties. This project is not only a significant investment in the health and well-being of Californians but also a model for the nation in advancing behavioral health care through innovation and collaboration.

Thank you for considering our support of this initiative. Should you have any questions, I can be contacted at john@steinberginstitute.org

Sincerely,

John Drebinger III
Senior Advocate

AGENDA ITEM 8

Action

May 23, 2024 Commission Meeting

May Revise Budget Update

Overview of the 2024 California May Revise

Introduction

The 2024 California May Revise is a crucial document that provides insights into the state's financial plan for the upcoming fiscal year. It outlines the revenue sources, expenditure proposals, and policy initiatives proposed by the governor's office. The proposed budget will serve as a roadmap for the state's fiscal decisions and priorities.

The May Revision estimates that the budget shortfall has grown by approximately $7 billion. Combined with the Governor's Budget, the budget shortfall for the 2024-25 fiscal year is approximately $44.9 billion. However, after accounting for early action budget package that included $17.3 billion of solutions, the remaining budget problem is approximately $27.6 billion.

Budget Proposal and Mental Health:
Governor Newsom's May Revision proposal for the 2024-25 fiscal year ensures a balanced budget over the next two fiscal years. The state is projected to achieve a positive operating reserve balance, both in this budget year and the next. California will make $3.3 billion available by July for counties and private developers to build more behavioral health treatment centers.

Historic Mental Health Transformation:
The passage of Proposition 1, on the March 2024 ballot overhauls California's mental health system, including a $6.4 billion bond for 10,000 new treatment beds and supportive housing units. These efforts aim to improve mental health services and support for Californians.
To address the projected budget shortfall and multiyear operating deficits, the Budget proposes one-time and ongoing General Fund solutions to achieve a balanced budget in both the 2024-25 and 2025-26 fiscal years and significantly reduce the projected operating deficit over the multiyear forecast.

MHSA/BHSA Relevant Adjustments

- **Healthcare Workforce Reduction**—Eliminating $300.9 million in 2023-24, $302.7 million in 2024-25, $216 million in 2025-26, $19 million in 2026-27, and $16 million in 2027-28 for various healthcare workforce initiatives including community health workers, nursing,

social work, Song-Brown residencies, Health Professions Career Opportunity Program, and California Medicine Scholars Program. The May Revision also **eliminates $189.4 million Mental Health Services Fund** for programs proposed to be delayed to 2025-26 at Governor's Budget.

- **Children and Youth Behavioral Health Initiative**—Reducing $72.3 million one-time in 2023-24, $348.6 million in 2024-25, and $5 million in 2025-26 for school-linked health partnerships and capacity grants for higher education institutions, behavioral health services and supports platform, evidence-based and community-defined grants, public education and change campaign, and youth suicide reporting and crisis response pilot.

- **Behavioral Health Continuum Infrastructure Program**—Eliminating $450.7 million one-time from the last round of the Behavioral Health Continuum Infrastructure Program, while maintaining $30 million one-time General Fund in 2024-25. Behavioral Health

- **Bridge Housing Program**—Reducing $132.5 million in 2024-25 and $207.5 million in 2025-26 for the Behavioral Health Bridge Housing Program, while maintaining $132.5 million General Fund in 2024-25 and $117.5 million **($90 million Mental Health Services Fund** and $27.5 million General Fund) in 2025-26.

State Administration, Employee Compensation and Other Statewide Adjustments

- Vacant Positions Funding Reduction and Elimination of Positions—Chapter 9, Statutes of 2024 (AB 106) adopted the Governor's Budget proposal to reduce departmental budgets in 2024-25 by $1.5 billion ($762.5 million General Fund) for savings associated with vacant positions. The May Revision proposes making the reduction permanent. The Department of Finance will work with agencies and departments in the fall on the appropriate budget reductions starting in 2024-25 and will eliminate approximately 10,000 positions starting in 2025-26 and ongoing.

- Ongoing Reductions to State Operations—Proposing an across-the-board reduction to state operations by approximately 7.95 percent beginning in 2024-25 to nearly all department budgets. The planned reduction involves all categories, including personnel, operating costs, and contracting. The Department of Finance will work with agencies and departments in the fall on the appropriate budget reductions.

Mental Health Services Oversight and Accountability Budget Overview

Total, Expenditures

	2022-23	2023-24	2024-25
Local Assistance	$114,169	$70,965	$34,306

State Operations and Local Assistance	$137,808	$126,182	$48,304

May revision proposes to:

- Increase the Commission's budget by 3 PY's and approximately $394,000 ongoing Mental Health Services Act funds to support the new Proposition 1 requirements.
- Provide $100,000 for the next 3 years to facilitate the name change from Mental Health Services Oversight and Accountability Commission to the Behavioral Health Services Oversight and Accountability Commission and provide staff training.
- Revert $7.6 million from the Mental Health Student Services Act for fiscal year 2023-24.

Presenter(s): Norma Pate, Deputy Director

Enclosures: Link: 2024-25 May Revision Budget Summary (ca.gov)

Handouts: PowerPoint slides will be made available at the Commission Meeting

Proposed Motion: None

AGENDA ITEM 9

Information

May 23, 2024 Commission Meeting

2024-27 Strategic Plan Update

Summary:
The Mental Health Services Oversight and Accountability Commission's 2024-2027 Strategic Plan guides the Commission's efforts over the next four years. As directed by the Commission, staff have developed a process for implementing tracking progress of the Strategic Plan goals and objectives.

Strategic Plan Goals

The Commission's vision is that all Californians experience wellbeing through a coordinated system that prioritizes prevention, early intervention, and recovery-oriented services; builds on the strengths of communities and marginalized groups; and creates opportunities for individuals to engage in meaningful and purposeful activities and helps them to thrive. Toward this vision, the Commission has identified four key strategic goals to guide its work.

1. Champion vision into action – so policymakers and the public understand and support the development of effective services and supports to reduce personal suffering and the heartbreaking consequences of unmet mental health needs.

2. Catalyze best practice networks – to ensure access, improve outcomes, and reduce disparities – to close the gap between what can be done and what is being done.

3. Inspire innovation and learning – to close the gap between what can be done and what must be done.

4. Relentlessly drive expectations – in ways that reduce stigma, build empathy, and empower the public to drive accountability for outcomes.

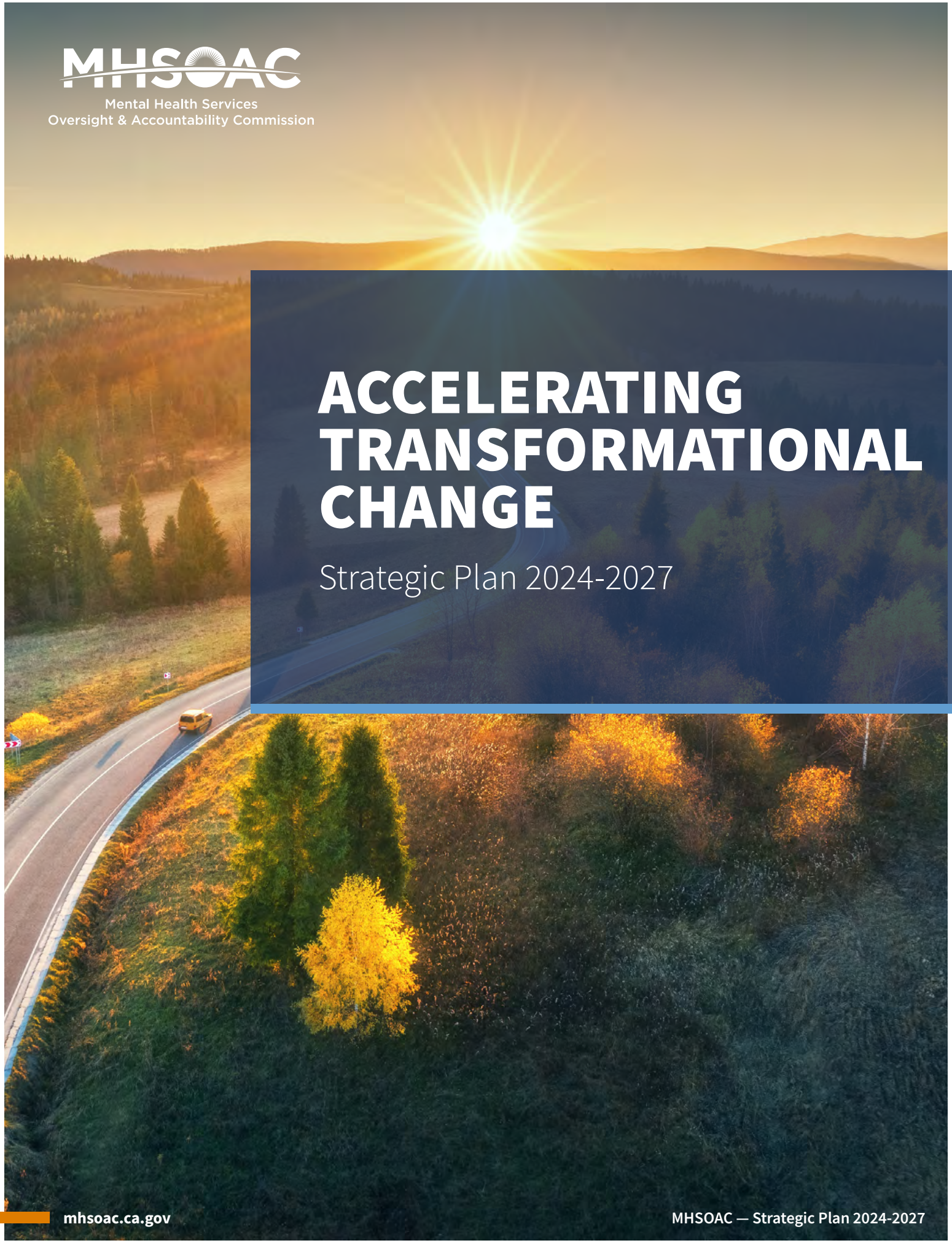
Implementation Appendix

To support the Commission's deliberations, staff have developed a strategic implementation plan with metrics for tracking and reporting progress against its strategic goals and objectives.

Presenter(s): Norma Pate, Deputy Director

Enclosures (3): (1) Strategic Plan – As adopted by the Commission; (2) Portfolio at a Glance – Provides a high-level overview of the Commission's strategic goals, capabilities, and its current initiatives and priorities; (3) Implementation Appendix

Handout: PowerPoint Presentation


MHSOAC
Mental Health Services
Oversight & Accountability Commission
ACCELERATING TRANSFORMATIONAL CHANGE
Strategic Plan 2024-2027
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MHSOAC — Strategic Plan 2024-2027

Mental Health Services
Oversight & Accountability Commission

Dear Community Partners,

As Chair of the Mental Health Services Oversight and Accountability Commission, I am pleased to present the Commission's Strategic Plan for 2024-2027. The Commission is undoubtedly vital to ensuring that behavioral health care in California is accessible, high-quality, and effective.

The Commission's Strategic Plan is not just a document, but a roadmap for transformational change. Over the next four years, our actions will be guided by the goals and objectives outlined in this plan.

The voices of our community partners, including diverse interest groups and racial and ethnic communities, were instrumental in shaping this Strategic Plan. Through a collaborative process that included public hearings, over 40 interviews, seven public meetings, two online surveys, and a focus group, these partners shared feedback and concerns. Their input has enriched and fortified the plan, making it more comprehensive and impactful.

The need for transformative change in California's behavioral health system has never been more urgent. That's why the Commission's North Star Priority for 2024-27 is clear: Accelerate system-level improvements that lead to early, effective, and universal access to services. This priority will guide the Commission's initiatives and projects.

California's behavioral health care system is poised for historic change, fueled by a once-in-a-generation investment and public attention. Seizing this moment to achieve significant change will require ambitious, collective action to integrate and improve the system.

To realize the transformative vision established by the Mental Health Services Act, we must institute additional improvements across policies, institutions, agencies, and services. The Commission will serve as a catalyst for this change by strategically deploying collaborative partnerships and our own capabilities.

Our journey toward achieving these goals requires a unified effort. We will actively engage with health care providers, community organizations, and government agencies to identify gaps in behavioral health services. Together, we will develop and implement effective solutions. Through this collective endeavor, we can leverage our combined expertise and resources to improve the behavioral health system for all Californians.

Lastly, the Commission is committed to fostering a culture of continuous improvement in behavioral health service delivery. We will provide opportunities for continuous learning and professional development for mental health service providers. Moreover, we will champion a culture of innovation and creativity, encouraging providers to explore new approaches and evidence-based practices. By fostering a culture of continuous improvement, we can ensure that California's behavioral health system remains responsive to the needs of individuals and their families.

In conclusion, the Commission is committed to improving behavioral health services in California. Our strategic plan is laser-focused on expanding access, enhancing quality, upholding accountability, and providing transparency. Through collaborative efforts, data collection, and information sharing, alongside a culture of continuous improvement, we will strive to progress toward our mission and vision.

We extend our heartfelt gratitude for your unwavering engagement and collaboration in our shared mission to enhance behavioral health services for every Californian. Together, we can make a meaningful difference in the lives of individuals and families across our state.

In service,

Mara Madrigal-Weiss
Chair

CONTENTS

Accelerating Transformational Change

STRATEGIC PLAN 2024-2027

California's future as a prosperous, compassionate, and healthy state is increasingly linked with the behavioral health and wellbeing of all of its residents.

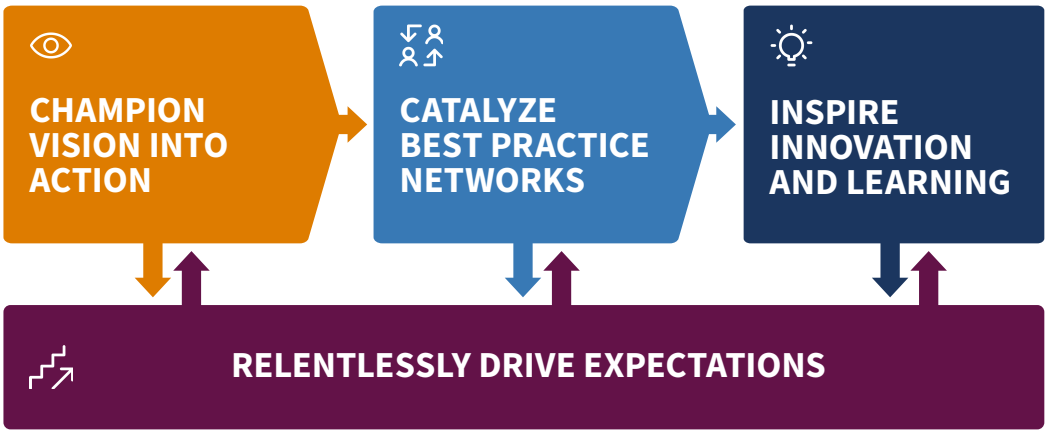
This reality motivated the Mental Health Services Oversight and Accountability Commission when it advocated for and launched the Mental Health Student Services Act, worked with pioneering counties to elevate early psychosis intervention, and promoted universal access to youth drop-in centers.

Similarly, the Commission worked with communities to improve full service partnerships, coordinate crisis response, and develop a state suicide prevention plan – strategies that can reduce incarceration, hospitalization, and homelessness.

These initiatives demonstrate the possibilities and the imperative to develop comprehensive systems of care essential to reducing disparities in access to culturally competent services and promoting recovery and wellbeing for all.

This strategic plan sharply focuses the Commission on accelerating the adoption of these individual services and integrating them into complete community-based behavioral health systems that provide early, integrated, and tailored services to everyone.

This "North Star priority" will be pursued by four foundational actions animated in the plan's goals:



1. **Champion vision into action** – so policymakers and the public understand and support the development of effective services and supports to reduce personal suffering and the heartbreaking consequences of unmet mental health needs.
2. **Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities** – to close the gap between what is being done and what can be done.
3. **Inspire innovation and learning** – to close the gap between what can be done and what must be done.
4. **Relentlessly drive expectations** in ways that reduce stigma, build empathy, and empower the public to drive accountability for outcomes.

A Point of Inflection

The behavioral health service system in California is at a threshold, defined by growing public needs, awareness, and empathy; by powerful new knowledge and promising practices; and by the imperative to better serve those with serious and chronic conditions while striving to prevent and intervene early to preserve and nurture health and wellbeing.

Californians are experiencing a mental health and substance abuse epidemic, made increasingly acute by a global pandemic, a strained workforce, and diminished social safety nets for communities that need them most.

The Governor and Legislature have recognized this imperative in launching initiatives such as the Children and Youth Behavioral Health Initiative and in developing revisions to the Mental Health Services Act (MHSA) that will go before voters for their approval on the March 2024 ballot.

There has never been more funding and momentum to drive transformational change, or such significant opportunities to advance innovations in behavioral health treatment and delivery models. Still, more work is required to build the vibrant system that the MHSA envisions.

To develop this strategic plan, the Commission consulted with numerous communities and multiple partners, reflected on the progress that has been made, and identified the right next steps for advancing transformational change.

The priorities and goals defined in this plan build upon the Commission's charge, its demonstrated capacity to drive improvements, and its stewardship of the MHSA's core values of person-centered and culturally competent care; of prevention, early intervention, and innovation; and of collaboration across agencies and communities to reduce inequities and disparities – all of which endure regardless of the March ballot results.

Meaningful Progress

By enacting the MHSA in 2004, voters made a foundational commitment to fund and transform California's mental health system of supports and services. To advance these commitments, the Commission in recent years has partnered with communities, other public agencies, and the private sector to identify critical gaps in the service system and directed technical assistance and resources to encourage a more proactive and comprehensive approach.

To accelerate learning and adaptation, the Commission worked with counties to invest $800 million in MHSA innovation funds and provided more than $400 million in incentive grants.

The Commission grew the state's Early Psychosis Intervention Plus programs, rapidly deployed some $150 million statewide to support mental health wellness programs in schools, developed a state prevention and early intervention framework and voluntary standards for workplace mental health, and empowered the advocacy efforts in eight underserved communities.

The Commission worked with counties to strengthen the wrap-around support of full service partnerships, improve crisis response, and reduce avoidable incarceration. It developed and began the implementation of a state suicide prevention strategy and re-prioritized $2.2 million to address disparities and fortify youth suicide prevention efforts.

Through all of these efforts, the Commission worked with its partners to raise awareness and elevate expectations for a maturing mental health system focused on prevention, recovery, and resilience in all communities.

Emerging Themes

CHALLENGES AND OPPORTUNITIES

The mental health landscape in California is evolving, and the Commission has a unique ability to rapidly respond to changing circumstances.

The mental health crisis was an epidemic before the COVID-19 pandemic exacerbated negative trends. Challenges such as homelessness, substance use disorders, and youth suicide continue to worsen throughout the state. Marginalized LGBTQIA+ populations and California communities of color face significant obstacles to receiving services. Mental health practitioners and resources have never been under greater strain.

Growing demands for behavioral health services

The COVID-19 pandemic brought significant challenges as more Californians and families experienced mental health challenges and the growing substance abuse epidemic firsthand.

Mental health needs, especially in youth and children, are intensified by isolation and the impact of social media. Mental health is the number one reason children ages zero to 17 are hospitalized and suicide is the number two cause of death for young people ages 10 to 24.[i] Marginalized and excluded populations, including those who identify as Black and Brown, Native American, Asian American, and Pacific Islander; girls and women; the LGBTQIA+ community; and those with disabilities continue to face heightened challenges. Structural inequities and macro threats, such as racism, the climate crisis, socioeconomic inequality, housing instability, and gun violence, also lead to worse mental health outcomes and an increased need for mental health care and supportive services.

Behavioral health elevated as a shared priority

Through the MHSA, communities are prioritizing prevention, early intervention, community-defined practices, innovation, and engaging people with lived experiences. Young people are publicly discussing mental health, while community groups, schools, and counties are collaborating to deliver needed care. This momentum is elevating mental health as a policy and funding priority. One-time funding through the California Children and Youth Behavioral Health Initiative, Student Behavioral Health Incentive Program, and the Mental Health Student Services Act are being reinforced by reforms to existing systems such as CalAIM.

Mental health is attracting the attention of philanthropies and private investors. From 2018 to 2020, over $9.8 billion was donated to mental health causes.[ii] Venture capital funding for digital mental health start-ups increased from $25 million in 2011 to more than $2.5 billion in 2020.[iii]

Evolutions in treatment & care delivery

The rise of mobile devices and digital capabilities has revolutionized telehealth services, with the share of tele-behavioral health outpatient visits doubling from 2019 to 2021.[iv] Recent innovations in diagnostic technology and services are changing the mental health care landscape. For example:

- New medicines show promising results for treating chronic depression.
- Emerging interest in psychedelics offers hope for improving options for treating disorders like major depressive disorder and post-traumatic stress disorder.[v]
- Future breakthroughs in precision medicine are expected to improve disease classification, shorten treatment duration, and limit suboptimal treatment outcomes.[vi]

State Mental Health Commissioner Steve Carnevale during a site visit looking into the impact of disaster on student mental health and how school districts might respond in February 2024 at Sonoma Valley High School.

In tandem, care delivery is improving. Integrated community care with a "no wrong door" approach, the shift of mental health care into primary care settings, expanded roles for peer providers, and the adoption of wrap-around services show promising signs for making care more accessible and effective for every Californian. These evolutions increase the need to integrate fragmented funding sources, streamline regulations, and evaluate the efficacy of programs to ensure that the highest quality of service is being delivered to Californians regardless of the delivery model.

Strain on practitioners, resources, and consumers

Pressure on practitioners and financial resources has grown dramatically over the last four years, creating even more challenges for consumers to access care. This includes:

- Nationwide shortage and burnout of behavioral health workers. Some 50% of behavioral health providers have experienced burnout and 30% of providers left their job.[vii]
- Lack of culturally competent practitioners with lived experience. Barriers include low pay, lack of career pathways, and credentialing and licensing requirements.[viii]
- Inadequate financial resources. Low reimbursement rates, difficulty billing private insurers for services, and severe financial strain on hospitals contribute to soaring provider costs.[ix]
- System fragmentation and capacity constraints are complex for consumers to navigate.
- Nearly 9.4 million Californians live in communities without enough mental health professionals.[x]

Accelerating pace of change

More change is likely to come even quicker in the future. The next decade is expected to bring a better understanding of and responses to the impacts of genAI and social media, as well as promising innovations in consumer-centered care.

To succeed in the next decade, California needs a resilient system that can direct and integrate resources to changing needs. Public agencies, including the Commission, will need to adapt priorities and strategies in response to the opportunities and impacts of these trends.

MHSOAC Commissioner Rayshell Chambers (second from right) speaks during presentations at the UCSF Weill Institute for Neurosciences.

The Imperative for Transformational Change

The next four years have the potential to be a turning point in the history of mental health care in California. Once-in-a-generation investment and public attention have set the stage for transformational change, but it will take ambitious, collective action to integrate and improve California's underlying mental health system.

The MHSA was designed to improve financing, design, and distribution of mental health services through local systems of care. Twenty years later, too many Californians still suffer from the seven negative

outcomes the act seeks to reduce: suicide, incarceration, school failure, unemployment, prolonged suffering, homelessness, and child welfare involvement.

To fulfill the MHSA's vision for transformational change, additional improvements are required in policies, institutions, agencies, and services. Transformational change requires:

- **Evolving the fragmented and siloed services** into an integrated, culturally competent system of care that is accessible regardless of geography or cultural background.
- **Empowering communities** – especially the most vulnerable, high-risk, and historically disadvantaged residents – so their needs and priorities are understood, they can participate in the design of services, and they can advocate for continued improvement.
- **Resourcing state and local agencies** and service providers so they have the capacity and workforce to manage toward better outcomes and continuous improvement across communities, services, and providers.

The Commission will catalyze this change by working through partnerships and strategically deploying its capabilities.

The Strategy to Advance Transformational Change

The Commission has supported system-level change by working closely with policymakers to align funding and authority and with counties to build their capacity to improve their response to escalating needs. With that experience, the Commission refined its core building blocks as a foundation for its future initiatives.

Core Strategic Building Blocks

Vision & Mission

Work with the public and system partners to fulfill our purpose of transformational change

Guiding Principles

Drive what we do and how we do it via our principles, values, and beliefs

Roles

Connect community, expert, and system partners through our formal and operational responsibilities

Capabilities

Drive improvements in policy, practice, and public expectations as a result of our skills and abilities

Strategic Priorities

Focus on the highest and best opportunities to reduce suffering and improve wellbeing

Initiatives

Design projects to drive system-level improvements and transformational change

The Commission's Vision

All Californians experience wellbeing through a coordinated system that prioritizes prevention, early intervention, and recovery-oriented services; builds on the strengths of communities and marginalized groups; and creates opportunities for individuals to engage in meaningful and purposeful activities and helps them to thrive.

The Commission's Mission

The Commission works to transform systems by engaging diverse communities and employing relevant data to advance policies, practices, and partnerships that generate understanding and insights, develop effective strategies and services, and grow the resources and capacity to improve positive behavioral health outcomes for every Californian.

Guiding Principles

The Commission's guiding principles and core values reflect its aspirations for the behavioral health system and guide decisions:

- Authentic collaboration with diverse communities is required to reduce disparities and improve equity.
- Outreach and engagement with individuals impacted by the behavioral health system of care is an essential element of program effectiveness.
- Tailored and culturally sensitive and competent services and supports are required for wellness and recovery.
- Accessible, affordable, and high-quality whole-person services and supports are required to improve outcomes.
- Public understanding and partnerships across agencies and communities are essential to aligning resources, improving services, and growing the capacities to serve everyone.
- A diverse, valued, and resilient workforce is foundational to high-quality services and reducing disparities.
- Innovation and continuous improvement are required to achieve individual and societal wellbeing.

The Commission's Roles

The Commission, with support from the Governor and the Legislature, has developed the distinct roles required to shape policies and drive practices and system-level improvements. The roles advance the charge in the MHSA for the Commission, with its diverse public membership, to champion prevention, early intervention, comprehensive services, and innovation as essential to an effective community mental health system.

COMMISSION'S ROLES IN DRIVING SYSTEM CHANGE

Build understanding of the potential to improve wellbeing and champion a common commitment to support the behvioral health of all Californians.

Accelerate adoption of best practices to facilitate deployment and ensure the effectiveness of best practices proven to reduce the consequences of untreated behavioral health issues.

Catalyze innovations to develop better practices to advance human-centered iteration, disseminate learnings, and support the deployment of new administrative practices, services, and supports that address needs inadequately met by existing services.

Provide accountability and oversight of system-level performance to understand and communicate the status of system improvement efforts and to recommend additional reforms to policies and practices.

The Commission's Capabilities

To successfully advance its mission, the Commission relies on a strategic set of capabilities and tools aligned with the purpose:

- **DRIVING POLICY**
  Research, public engagement, policy development, and advocacy
- **DRIVING TRANSFORMATIONAL CHANGE**
  Assessment of system performance and opportunities for improvement
- **DRIVING PRACTICE**
  Financial incentives, technical assistance, and evaluation

Having refined its roles and its capabilities, the Commission seeks to improve its abilities to precisely assess where interventions can reduce the most harm and produce the most benefit.

Decision-Making Approach

The Commission seeks to strengthen its capacities to select, design, and manage initiatives and projects so that they produce enduring system-level improvements. Toward that end, the Commission is developing a decision-making framework to help determine whether and how to pursue projects. Over time, the Commission aspires for the framework to evolve so as to differentiate among opportunities to allocate finite resources. The first generation of the framework is intended to:

- Ensure the Commission's guiding principles are integrated into all future activities.
- Understand with precision individual opportunities to improve systems and services.
- Design and evolve programs to address community priorities and maximize outcomes for recipient communities.
- Standardize and strengthen its approach to collecting and using data to measure the impact of a project.
- Define success for each opportunity, identify the level of effort and resources required to deliver, and calibrate investments.

NEED

- What are the implications of the unmet need for individuals and communities?
- What are the causes of the unmet need; what has been tried before?
- How does the need contribute to disparities in services and outcomes?
- What are the downstream consequences to individuals and communities?

IMPACT

- How will the project enables agencies and providers to tailor services to reduce disparities?
- How will the project advance services models and enable replications?
- How will the project change and improve the system of care?
- What are the expected benefits to population behavioral health?

FIT

- How does the project advance the North Star goal?
- How well does the project compliment existing projects?
- How would the Commission deploy or augment its capabilities?
- How well is the Commission positioned to be successful?

FEASIBILITY

- What is the definition of success and the metrics to track progress?
- How will the project produce self-sustaining system improvements?
- How would the Commission allocate or acquire resources?
- Who are the partners who would champion the work?

The framework will encourage alignment among Commissioners and communicate clearly with public partners. The framework has the potential to improve the impact of the Commission's portfolio of projects and the success of individual projects. The framework has four key criteria to guide decision-making:

1. **NEED**
   A precise understanding of the unmet needs, including the causes and consequences of inaction and the implications for individuals, communities, and the state.
2. **IMPACT**
   The potential to benefit individuals and communities, to reduce disparities, to advance a comprehensive system of care, to produce cost-effective outcomes, to be financially sustained over time.
3. **FIT**
   The extent to which an opportunity aligns with the Commission's mission, strategic priorities, and roles and will work synergistically with existing initiatives to advance a comprehensive system of care.
4. **FEASIBILITY**
   The extent to which the opportunity has a clear definition of success and path to sustainability given the level of effort required and the available resources.

The framework will be deployed, assessed, and refined when the Commission has discretion to select new initiatives or investments or when implementing legislatively directed projects. The framework also will be modified for selecting and designing innovation projects.

Strategic Priorities & Initiatives

The Commission's portfolio of initiatives has demonstrated the potential for effective community-based services to prevent and reduce the tragic outcomes of untreated mental health needs.

In the last four fiscal years, the Commission's 10+ initiatives have directed some $442 million across the continuum of care, including significant investments in the following areas:

- Early psychosis and suicide prevention by scaling innovative Early Psychosis Plus programs statewide, guiding the implementation of the state's Striving for Zero Suicide Prevention Strategic Plan, and supporting the Office of Suicide Prevention to coordinate and accelerate efforts.
- Youth mental health with more than $200 million allocated through the Mental Health Student Services Act, allcove® Youth Drop-In Centers, an anti-bullying campaign, and support for youth and peer empowerment programs.
- Integrated community treatment including supporting counties' crisis continuum of care services via the Mental Health Wellness Act and improving Full Service Partnerships.
- Criminal justice intervention by helping 26 counties participating in six learning collaboratives to develop and deploy data-driven and financially sustainable alternatives to law enforcement responses and incarceration.

In demonstrating the potential for transformational change, these initiatives have also elevated the imperative to increase the pace and scale of efforts to build a comprehensive community-based system, bringing into sharp focus the near-term priority.

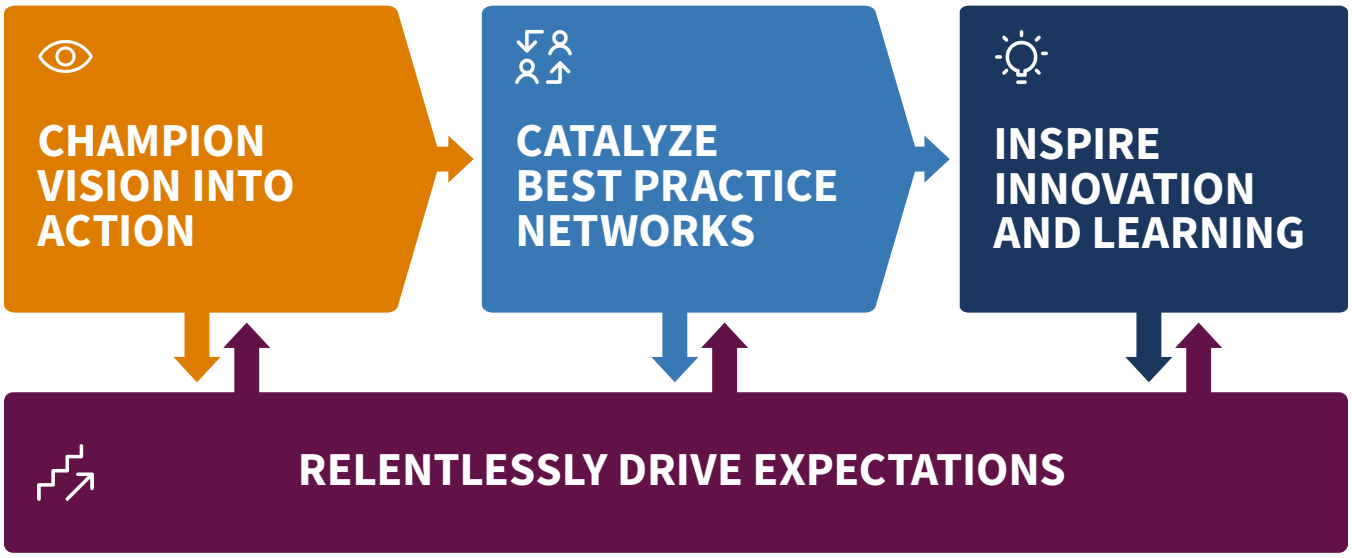
The Commission's 2024-27 North Star priority: Accelerate system-level improvements to achieve early, effective, and universally available services.

This priority will guide the evolution and design of the Commission's initiatives and projects, further informed by three more clearly defined Operational Priorities:

- **BUILD FOUNDATIONAL KNOWLEDGE.**
  The Commission will more explicitly develop and advocate for data-based and community-derived information to drive decisions regarding finances and services toward adequacy, sustainability, efficiency, effectiveness, and reductions in disparities.
- **CLOSE THE GAP BETWEEN WHAT IS BEING DONE AND WHAT CAN BE DONE.**
  The Commission will work to accelerate the adoption of effective programs to reduce geographic, demographic, cultural, and socio-economic disparities in services, supports, and outcomes.
- **CLOSE THE GAP BETWEEN WHAT CAN BE DONE AND WHAT MUST BE DONE.**
  The Commission in new ways will drive innovation in the public-private financing, delivery of services and supports, and continuous improvement to accelerate the development of early, effective, integrated, and universally available services and supports.

Goals and Objectives for 2024-2027

The Commission will pursue its North Star priority by working with community members, experts, and governmental and civic partners to achieve the following goals.



GOAL 1

Champion Vision into Action

The Commission will analyze data and engage all partners to advance the evolution of policies necessary to provide an early, effective, and universally available system of behavioral health supports and services.

OBJECTIVE 1

Elevate the perspective of diverse communities.

The Commission will partner with local agencies and community organizations to engage all people with lived experience, their families, and neighbors to understand the impacts of the current systems; identify opportunities for improving services and reducing disparities; and elevate concerns and suggestions to public and private system leaders.

OBJECTIVE 2

Assess and advocate for system improvements.

The Commission will assess and publish key opportunities for investments and changes in policies and practices that will move California toward a universally accessible, integrated, and effective system of care that prevents and reduces the incidence and consequence of mental health issues at the earliest possible moment.

OBJECTIVE 3

Connect federally and globally to learn and apply.

The Commission will Identify and engage in federal and international initiatives seeking to promote the North Star priority, assess how California could contribute or benefit from those initiatives, and convene and share that information with system and community partners in California.

GOAL 2

Catalyze Best Practice Networks

The Commission will engage public and private partners, including universities and institutes, to catalyze the creation of best practice networks of excellence. These dynamic networks will strive to accelerate the effective implementation of service models that work together to provide universal access to a system of high-quality supports and services. The networks will curate best practices, provide technical assistance, assess and address barriers to implementation, and identify policies and practices for continuous improvement.

The Commission will focus first on networks supporting its seminal efforts in school-based mental health, early psychosis intervention, allcove® youth drop-in centers, workplace mental health strategies, and full service partnerships. Specifically, the Commission will advance these elements that are essential to system change:

OBJECTIVE 1

Support organizational capacity building.

The networks should support the development of organizational partnerships, the collaborative use of data to assess services, the ability to design and implement change projects, and manage toward continuous improvement.

OBJECTIVE 2

Fortify professional development programs and resilient workforce strategies.

The networks should help to align and augment professional development programs to build the needs skills and abilities, develop educational pipelines for future staff that begin in the communities that are being served, and build career ladders that provide for individual growth and robust service systems.

OBJECTIVE 3

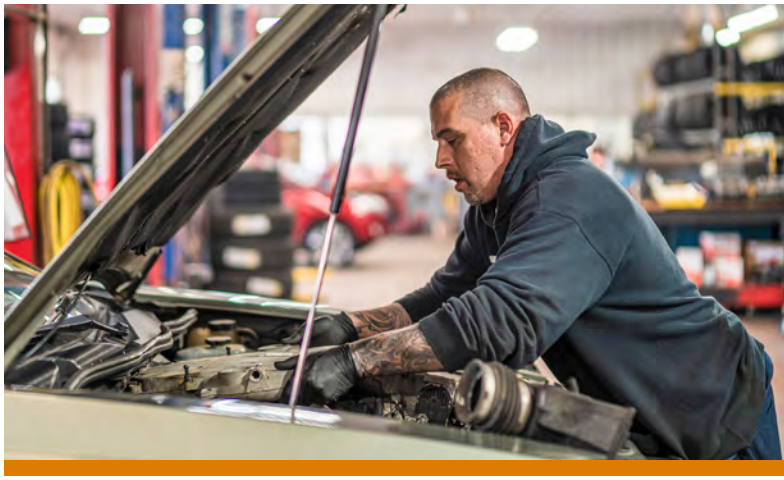
Develop adequate and reliable funding models.

The Commission will Identify and engage in federal and international initiatives seeking to promote the North Star priority, assess how California could contribute or benefit from those initiatives, and convene and share that information with system and community partners in California.

OBJECTIVE 4

Support system-level analysis to ensure the tailored care and universal access required to reduce disparities.

The networks should ensure efficient and informative research and evaluations inform public storytelling and understanding, improve practices and outcomes, and drive changes in state and federal policies, regulations, and program administration.



GOAL 3

Inspire Innovation and Learning

The Commission will develop strategies and partnerships to catalyze innovation and accelerate the development and dissemination of new models and practices that further improve behavioral health and wellbeing.

OBJECTIVE 1

Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.

The narrative will be supported and promoted through convenings and communications that bring together community voices, researchers, practitioners, and system leaders to explore opportunities, learnings, and future applications. These collaborative efforts will analyze opportunities, experimental projects, results, and impacts on individual lives, families, and neighborhoods.

OBJECTIVE 2

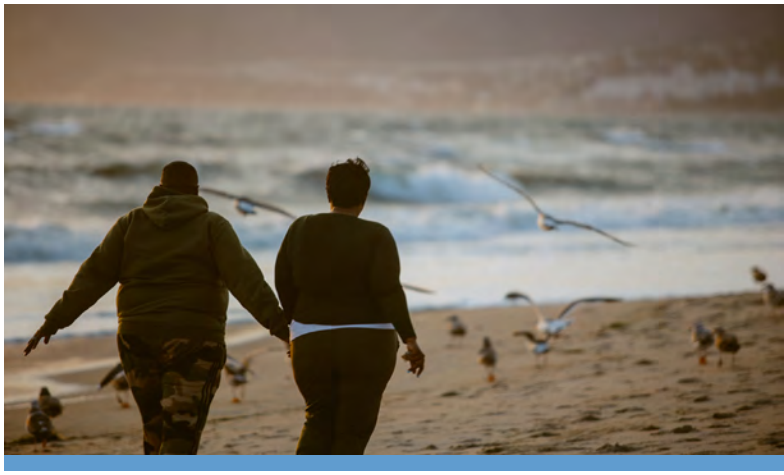
Establish an innovation fund to link and leverage public and private investments.

The fund will seek investors and partners who can help resource and shape projects to identify high-value learning opportunities with the potential to reduce disparities, improve the quality of life and public outcomes, and drive transformational change in behavioral health services and supports.

OBJECTIVE 3

Accelerate learning and adaptation in public policies and programs.

The Commission will initiate and participate in partnerships that elevate community voice and the public interest in innovation projects, as well as the learnings that should inform changes in statutes, budgets, and regulations.



GOAL 4

Relentlessly Drive Expectations

The Commission will work with all Californians to increase understanding, empathy, trust, and empowerment as a way to bolster public ownership, expectations, and accountability for improvement of the public behavioral health system.

OBJECTIVE 1

Launch a public awareness strategy to reduce stigma, promote access to care, and communicate the potential for recovery.

The strategy will be developed and managed with public partners, incorporate the Commission's major initiatives, and be tailored to racial and geographic communities to inform and empower Californians to improve access to care and make better decisions regarding behavioral health.

OBJECTIVE 2

Develop a behavioral health index.

The index will track and promote key indicators for behavioral health, including the seven negative outcomes, by county with benchmarks for peer counties, as well as peer states and nations to California.

OBJECTIVE 3

Promote understanding of the progress that is being made and the advocacy that will result in further improvements.

The Commission will work with community voices, especially youth, to build understanding of the potential for additional healing and to inform and empower their advocacy for improvements with service providers and public decision-makers.

From Plan to Action

The Commission is fortifying its internal project management, human resources, community engagement, and communications protocols to effectively pursue these goals and objectives.

The Commission expects this plan will evolve with changes in statutes, funding streams, community needs, and opportunities for impact over the coming years.

The Commission also is committed to measuring its impact and using that information for continuous improvement. The potential metrics in the succeeding table are illustrative and will be refined with partners while implementing the objectives.

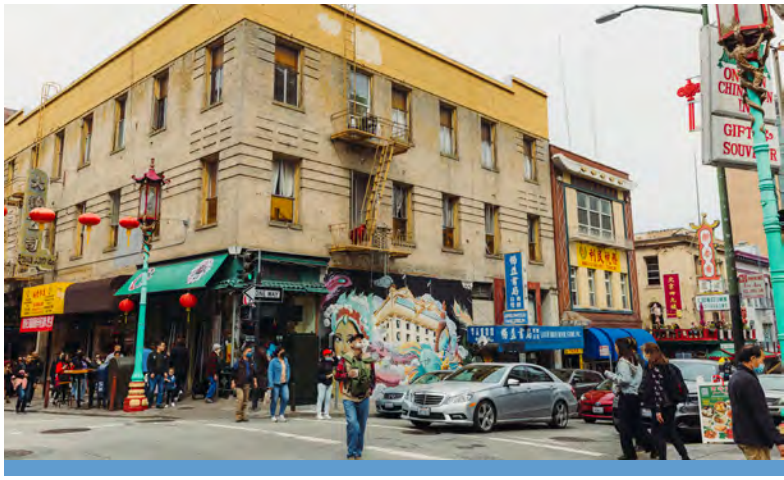
Goals, Objectives, & Metrics

Goal 1: Champion Vision to Action

GOAL & OBJECTIVES	METRICS
OBJECTIVE 1 **Elevate the perspective of diverse communities.**	Community engagement activities mapped by place, demographics, and mental health system involvement. The influence of community voice in state and local behavioral health decision-making as assessed by community members and decision-makers, and the resulting changes in policies and procedures. Assessment of the Commission's community engagement activities against established standards.
OBJECTIVE 2 **Assess and advocate for system improvements.**	Assessments of presentations and convenings; feedback received from public partners, public administrators, and policymakers; recommendations incorporated into policies and practices.
OBJECTIVE 3 **Connect federally and globally to learn and apply.**	Assessments of presentations and convenings; feedback received from the public partners, public administrators, and policymakers; recommendations incorporated into policies and practices.

Goal 2: Catalyze Best Practice Networks

GOAL & OBJECTIVES	METRICS
OBJECTIVE 1 **Support organizational capacity building.**	The number of local agencies and providers reached by the network, the number participating in adaptation projects, improvements in programs and services.
OBJECTIVE 2 **Fortify professional development programs and resilient workforce strategies.**	The number of education and training partners involved, the number of job classifications aligned, the number of community-based training pipelines developed, the number of counties with resilient workforce strategies, the number of unfillable job vacancies, retention, career advancement.
OBJECTIVE 3 **Develop adequate and reliable funding models.**	The number of service-based funding models developed, the number of counties maximizing Medi-Cal and private insurance funding, the percentage of services funded through entitlement programs, the percentage of services funded by private insurance.
OBJECTIVE 4 **Support system-level analysis to ensure the tailored care and universal access required to reduce disparities.**	The percentage of services covered by system-level reviews, the percentage of issues addressed by policymakers, administrators or providers, the percentage of coverage demographically and geographically for essential behavioral health services.



Goal 3: Inspire Innovation and Learning

GOAL & OBJECTIVES	METRICS
OBJECTIVE 1 Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.	Number and diversity of outreach activities, the number and diversity of participants embracing the narrative, feedback from participants on the value of the narrative.
OBJECTIVE 2 Establish an innovation fund to link and leverage public and private investments.	Amount of funds deployed, the range and diversity of investments, qualitative value of learnings.
OBJECTIVE 3 Accelerate learning and adaptation in public policies and programs.	Number and diversity of projects, the learnings derived, the learnings incorporated into policies and practices.

Goal 4: Relentlessly Drive Expectations

GOAL & OBJECTIVES	METRICS
OBJECTIVE 1 Launch a public awareness strategy to reduce stigma, promote access care, and communicate the potential for recovery.	Quantity and diversity of outreach efforts, data on readership, responses to queries on the value of content.
OBJECTIVE 2 Develop a behavioral health index.	Number and diversity of project partners, number and diversity of those who access the index, feedback from system partners.
OBJECTIVE 3 Promote understanding of the progress that is being made and the advocacy that will result in further improvements.	Number and diversity of organizations and individuals involved in activities, feedback from participants on the value of their engagement, feedback from system partners on the value of resulting advocacy.

Summary of Themes from Community Engagement

The Commission engaged the public between May and November 2023 to inform the development of the strategic plan. Multiple methods were employed to reach and engage community partners, including more than 40 interviews with internal and external partners, six public meetings, two online surveys, and a focus group. Through these strategies, a diverse audience representing different interest groups and racial and ethnic backgrounds expressed their needs and concerns.

The Commission received a tremendous amount of input and feedback from community partners through the engagement efforts. To distill what was heard, transcripts and summaries were produced of all engagement events and then analyzed to identify core themes. The table below presents those themes, which informed every aspect of the 2024-2027 Strategic Plan.

	KEY THEMES	QUOTES
1	**Provide strong leadership, vision, focus, and promote awareness**	"The Commission is in the best position to see the statewide perspective on mental health issues and provide some policy continuity while still recognizing unique regional issues and needs." "Increasing awareness about mental illnesses and mental health in general population. Decreasing the stigma around and misunderstanding of mental disorders and illnesses."
2	**Engage community, build trust, and empower**	"Your willingness to reach out to the public and diverse communities of California State. Allowing community to speak about what they need." "Shaping the Mental Health System in California involves power in numbers and a willingness to include all voices and feedback from consumers, families, and community partners. 'Nothing about us, without us.'"
3	**Develop policy, support legislation, and advocate for services**	"Advocate for Housing that Heals! We need supportive housing for clients in their own county of residence. Extra financial help is needed for small, rural counties. Too many of our clients have to be sent out of our County for placement."
4	**Promote prevention/early intervention and school mental health**	"Promote mental health and well-being for school kids, to drive multi-generational impact in years to come. This can be done by educating the public about mental health, supporting PEI programs, and promoting mental health focus at schools." "The Commission's key opportunity is to fill a significant gap in both funding and partnership in supporting mental health in our school (LEA) eco-system."

	KEY THEMES	QUOTES
5	Allocate resources strategically, provide technical assistance, and support best practice models	"The Commission's highest impact role is its approval and awarding of funding for impactful county projects, community programs, and advocacy initiatives." "Commission staff has good experience administering contracts in order to decrease disparities, increase community engagement, and implement pilot projects."
6	Address disparities and ensure services are culturally competent and sensitive	"Most important in my community are mental health disparities, particularly for the African American population, gang-involved/affected." "African Americans are overrepresented in criminal justice, foster care, etc., and they need to be treated and receive specialized services."
7	Foster innovative practices/treatment and service integration	"Providing pathways for innovative programs to serve their communities and ensuring the counties are supporting the state initiatives." "Encouraging and developing innovative approaches to mental health. Helping to create and support state-wide initiatives."
8	Leverage data to inform the public and improve services; standardize performance outcomes	"Have data collection for everything we're doing all across the board through all community organizations, and when people find what works, we need to put that out there and say this has been great for us or has helped me, but we need a strong data collection and have that open and available to everyone who uses the system." "The Commission can drive accountability for the system overall. For example, by requiring a standard of care for services purchased with MHSA dollars. Also, by gathering reliable and consistent data on access and performance, the Commission can demonstrate the value of data-driven policy and practice."
9	Build diverse workforce and support peer services	"One thing missing is peer support/peer services needed to support the mental health community through California, with ALL communities, especially SMI/ unhoused communities." "Using peers is an essential part of the process; I would like to add that maybe we can develop relationships with peers and use peers to help with/follow through for people with/ SMI." "An inclusive and compassionate workforce towards all employees is more likely to be engaged, motivated, and have higher levels of well-being."

Recent Commission Projects

These Commission projects reveal the value of engaging community perspectives, experts, public agencies, and service providers in efforts to improve services and outcomes – and the imperative to accelerate progress toward comprehensive community-based systems of care.

Criminal Justice Project

The Commission's report "Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness" recommended ways to prevent people with mental health challenges from becoming involved with criminal justice systems. The Legislature authorized $5 million to the Commission to develop the Innovation Incubator that worked with counties to implement the recommendations.

Suicide Prevention Project

Assembly Bill 114 directed the Commission to develop a statewide strategic suicide prevention plan, which resulted in the Commission adopting "Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025."

School Mental Health Project

The Commission's report "Every Young Heart and Mind: Schools as Centers for Wellness" recommended ways to increase mental health services through partnerships between county behavioral health departments and local education agencies.

Prevention and Early Intervention Project

In 2018, Senate Bill 1004 directed the Commission to strengthen prevention and early intervention in California's public mental health system. The Commission's report "Wellness and Thriving: Advancing Prevention and Early Intervention in Mental Health" provides a vision and framework to guide prevention and early intervention in mental health across California.

Workplace Mental Health Project

In 2018, Senate Bill 1113 directed the Commission to establish a framework for promoting mental health in the workplace. The Commission developed five voluntary standards that employers may adopt to support the mental health of employees.

Racial Equity Plan

The Commission's Racial Equity Action Plan builds on the Commission's understanding of the problem and fortifies Commission staff using diversity, equity, and inclusion best practices.

SOURCES

i. The 2020 California Children's Report Card

ii. Candid (2021)

iii. Rock Health (2021)

iv. Kaiser Family Foundation (2022)

v. World Economic Forum (2021)

vi. American Physiological Society (2023)

vii. Substance Abuse and Mental Health Services (2022)

viii. Healthforce Center at UCSF (2018)

ix. Association of American Medical Colleges (2022)

x. NAMI California (2021)

Mental Health Services
Oversight & Accountability Commission

Portfolio at a Glance

Objectives	Goal 1	Goal 2	Goal 3	Goal 4
	Champion Vision to Action	Catalyze Best Practice Networks	Inspire Innovation and Learning	Relentlessly Drive Expectations
	1. *Elevate the perspective of diverse communities.* 2. *Assess and advocate for system improvements;* 3. *Connect federally and globally;*	1. *Support organizational capacity building;* 2. *Fortify professional development programs and resilient workforce strategies;* 3. *Develop adequate and reliable funding models;* 4. *Support system-level analysis to reduce disparities;*	1. *Curate an analytical-based narrative on the potential for innovation;* 2. *Establish an innovation fund to link and leverage public and private investments;* 3. *Accelerate learning and adaptation in public policies and programs;*	1. *Launch a public awareness strategy;* 2. *Develop a behavioral health index;* 3. *Promote understanding of the progress being made and the advocacy that will result in improvements;*

Internal Processes and Capabilities					
Administration	Communications	Program Operations	Research and Evaluation	Community Engagement	Legislation/External Affairs

Working Portfolio			
School Mental Health • Student Services Act • Universal Child/Youth Screening • Empowering Youth	Learning Collaboratives • Youth Drop-in/allcove® • Early Psychosis Intervention • Psychiatric Advance Directives • EmPATH • Older Adults	Mental Health Wellness Act • Substance Use Disorder Services • Full Service Partnerships • Young Children 0-5 • Peer Respite	Peer Supports • Peer Certification • Peers in State Government • Peer and Practitioner Fellowships
Workplace Mental Health • Center of Excellence • K-12 • Higher Education	Innovation • Spending Approvals • $100 Million investment • Public-Private partnerships	Accountability and Transparency • Fiscal • Services • Outcomes	Research/Policy Projects • Criminal Justice Diversion • Suicide Prevention • Prevention and Early Intervention • Impacts of Firearm Violence

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Strategic Plan Implementation Outline

In adopting the 2024-2027 Strategic Plan, the Commission directed staff to develop a process for tracking and reporting progress against its strategic goals and objectives. This document provides draft metrics, including aspirational metrics, in support of that goal. Staff are working to develop implementation strategies for this process and recognize that the metrics may evolve.

Goal 1: Champion Vision into Action

The Commission will analyze data and engage all partners to advance the evolution of policies necessary to provide an early, effective, and universally available system of behavioral health supports and services.

Objective 1.1: Elevate the Perspective of Diverse Communities

i. **Commission community engagement:**
   - Number of engagement events.
   - Number and description of populations and partners engaged.
   - Geographic distribution of engagement events and activities.
   - Goals of engagement (e.g., tied to initiative and/or strategic plan).

ii. **Sponsored community engagement:**
   - Number of engagement events.
   - Number and description of populations and partners engaged.
   - Geographic distribution of engagement events and activities.
   - Goals of engagement (e.g., tied to initiative and/or strategic plan).

iii. **Aspirational: Measure public trust in behavioral health programs among diverse communities.**

Objective 1.2: Assess and advocate for system improvements.

i. **Progress on development and implementation of Commission policy projects.**
   - Fiscal transparency
   - Criminal justice diversion
   - School mental health
   - Suicide prevention
   - Prevention and early intervention
   - Workplace mental health

- Impacts of firearm violence

Objective 1.3: Connect federally and globally to learn and apply.

i. **Reach, representation, and impact:**
   - Number of published articles, white papers, and policy briefs.
   - Number of external presentations and engagement.
   - Media coverage.
   - Legislation informed and/or supported by the Commission.

Goal 2: Catalyze Best Practice Networks

The Commission will engage public and private partners, including universities and institutes, to catalyze the creation of best practice networks of excellence.

Objective 2.1: Support organizational capacity building.

i. **Commission-supported capacity building initiatives and progress report for best practice networks:**
   - allcove®
   - Early psychosis
   - EmPATH
   - Full Service Partnerships
   - Workplace mental health
   - School mental health
   - … and future initiatives.

ii. **Aspirational: Curated repository of best practice research, evidence, toolkits, and related materials.**

Objective 2.2: Fortify professional development programs and resilient workforce strategies.

i. **Participation in the Transformational Change Partnership.**

ii. **Engagements with workforce funders.**

iii. **Investments in California's behavioral health workforce.**

iv. **Aspirational: Workforce adequacy and diverse representation.**

Objective 2.3: Develop adequate and reliable funding models.

i. **Funding secured for best practice networks.**

ii. **Analyses linking outcomes to finance.**

Objective 2.4: Support system-level analysis to ensure the tailored care and universal access required to reduce disparities.

i. **Commission-led policy research.**

ii. **Commission-supported policy research.**

iii. **Growth in external analysis supporting tailored care and universal access to reduce disparities.**

Goal 3: Inspire Innovation and Learning

The Commission will develop strategies and partnerships to catalyze innovation and accelerate the development and dissemination of new models and practices that further improve behavioral health and wellbeing.

Objective 3.1: Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.

i. **Commission-disseminated learnings from innovation.**

ii. **Engagements on public sector innovation.**

iii. **Best practices that result from innovation.**

iv. **Public interest and awareness in innovation (media monitoring).**

Objective 3.2: Establish an innovation fund to link and leverage public and private investments.

i. **Establishment of innovation fund.**

ii. **Funding secured.**

iii. **Investments made and return on investments.**

Objective 3.3: Accelerate learning and adaptation in public policies and programs.

i. **Engagements on public sector innovation.**

ii. **Best practices that result from innovation.**

iii. **Public interest and awareness in innovation (media monitoring).**

Goal 4: Relentlessly Drive Expectations

The Commission will work with all Californians to increase understanding, empathy, trust, and empowerment as a way to bolster public ownership, expectations, and accountability for improvement of the public behavioral health system.

Objective 4.1: Launch a public awareness strategy to reduce stigma, promote access to care, and communicate the potential for recovery.

i. **Progress report on launching a public awareness strategy. (Metrics to be developed)**

ii. **Aspirational: Statewide survey on stigma, public trust, understanding, and support for behavioral health.**

Objective 4.2: Develop a behavioral health index.

i. **Progress report on development of behavioral health index. (Metrics to be developed)**

ii. **Aspirational: California adopts a behavioral health index that is globally recognized for excellence.**

Objective 4.3: Promote understanding of the progress that is being made and the advocacy that will result in further improvements.

i. **Messaging strategies:**

- Podcast
- Social media
- Website
- Data visualizations
- Transformational Change Report

Operational Goal: Fortify Commission capabilities and processes

Operational Objective 1: Establish the Commission as employer of choice that attracts and retains a high performing workforce that reflects California's diverse communities.

i. **Employee satisfaction and engagement (survey).**

ii. **Employee retention.**
iii. **Size of candidate pool.**
iv. **Percentage staff participating in formal professional development activities.**
v. **Percentage staff formally contributing to the behavioral health field or their professional field.**
vi. **Demographic representation and diversity of staff, including self-reported peer status.**

Operational Objective 2: Meet and exceed state and national standards for IT performance.

i. **System uptime.**
ii. **Cybersecurity incidents.**
iii. **Additional metrics to be determined based on state/national IT standards.**

Operational Objective 3: Adopt and implement best practices in fiscal transparency and procurement.

i. **Budget to Commission.**
ii. **Monitor expenditures.**
iii. **Metrics to be determined based on national standards for fiscal transparency, procurement practices, and related opportunities.**

Operational Objective 4: Evolve Communication strategies.

i. **Messaging strategies: (see Objective 4.3 metrics)**
- Podcast
- Social media
- Website
- Data visualizations
- Transformational Change Report

Operational Objective 5: Support Commissioner engagement.

i. **Commissioner satisfaction (metrics to be determined).**

MISCELLANEOUS ENCLOSURES

May 23rd, 2024 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Rolling Calendar

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 4

Funds Spent Since the April 2024 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 100,000.00
22MHSOAC050	$ 0.00
23MHSOAC018	$0.00
TOTAL	**$ 100,000.00**

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: $4,244,350
Total Spent: $3,890,653.24

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	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	In Progress	06/30/2024	Yes

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $500,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	In Progress	December 15, 2023	No
School Mental Health Metrics	In Progress	June 15, 2024	No
Evaluation Plan (draft and final)	Not Started	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	In Progress	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete In Progress	September 15, 2023 January 15, 2024 June 15, 2024	No

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Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $285,000.00

This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

Deliverable	Status	Due Date	Change
Community Engagement Plan (draft and final)	Complete	August 31, 2023 September 30, 2023	No
Statewide Survey (draft and final)	Complete	October 31, 2023 December 31, 2023	Yes
Progress Reports (#1 and #2)	#1 Complete #2 Complete	October 31, 2023 March 31, 2024	Yes
Final Report (draft and final)	In Progress	March 31, 2024 June 28, 2024	Yes

The Regents of the University of California, San Francisco:: Universal Screening Project (23MHSOAC018)

MHSOAC Staff: Kali Patterson

Active Dates: 12/12/23 -12/31/24

Total Contract Amount: $160,000

Total Spent: $10,000

The project will support the Commission in conducting research on the subject of universal mental health screening for children and youth and conduct a landscape analysis to understand universal mental health screening policies and practices for children and youth in California. Doing so will allow the Commission, as part of its required legislative Report, to develop recommendations to improve universal screening of students in California schools.

Deliverable	Status	Due Date	Change
Survey Tool	Complete	02/01/2024	No
Literature Review Report	Complete	02/01/2024	No
Project Support and Consult a. Workplan b. Meetings and Interviews c. Analysis and Summary	a. In Progress b. Complete c. In Progress	1/15/2024 1/15/2024 4/30/2024	No
Landscape Analysis Report a. Draft Report b. Final Report	In Progress	06/30/2024 7/31/2024	No

Mental Health Services
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INNOVATION DASHBOARD

MAY 2024

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	4	0	**4**
Participating Counties (unduplicated)	4	0	**4**
Dollars Requested	$21,007,113	$0	**$21,007,113**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	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%)
FY 2022-2023	31	31	$354,562,908.86	26 (44%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2023-2024	10	10	$176,473,920	10

INNOVATION PROJECT DETAILS

FINAL PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Ventura	Early Psychosis Learning Health Care Network – Multi-County Collaborative	$10,137,474.63	4 Years	01/29/2024	5/2/2024
Under Final Review	Fresno	California Reducing Disparities Project - Extension	$2,953,244	2 Years	12/29/2023	2/27/2024
Under Final Review	Mendocino	Native Crisis Line – A Partnership between Pinoleville Pomo Nation and Mendocino County BHRS	$1,001,395	4 Years	4/10/2024	5/1/2024
Under Final Review	Fresno	PADs: Phase 2 – Multi-County Collaborative	$5,915,000	4 Years	4/21/2024	4/30/2024
Under Final Review	Shasta	PADs: Phase 2 – Multi-County Collaborative	$1,000,000	4 Years	4/21/2024	4/30/2024

DRAFT PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC

APPROVED PROJECTS (FY 23-24)

County	Project Name	Funding Amount	Approval Date
Santa Clara	TGE Center	$11,938,639	7/27/2023
San Luis Obispo	Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)	$860,000	9/28/2023
Santa Cruz	Crisis Now Multi-County Innovation Plan	$4,544,656	9/28/2023

APPROVED PROJECTS (FY 23-24)			
County	Project Name	Funding Amount	Approval Date
Amador	Workforce Retention Strategies	$1,995,129	9/28/2023
Tri-City	Community Planning Process	$675,000	10/26/2023
Los Angeles	Kedren Children and Family Restorative Care Village	$100,594,450	11/16/2023
Sacramento	allcove Multi-County Collaborative	$10,000,000	11/16/2023
Sutter-Yuba	Multi County FSP Project	$1,226,250	01/25/2024
Sacramento	Community Defined Mental Wellness Practices for the African American/Black/African Descent Unhoused	$15,500,231	01/25/2024
Riverside	Eating Disorder Intensive Outpatient and Training Program	$29,139,565	02/22/2024

DHCS Status Chart of County RERs Received
May 23, 2024, 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 May 3, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, 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 2022-2023 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 2021-22 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.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Alameda	1/31/2023	2/6/2023	2/7/2023	1/30/2024	1/31/2024	2/14/2024
Alpine	4/14/2023		4/17/2023			
Amador	1/31/2023	2/7/2023	2/17/2023	2/8/2024	2/8/2024; 2/14/24	2/16/2024
Berkeley City	1/31/2023	2/2/2023	2/7/2023	1/31/2024	2/2/2023	2/6/2024
Butte						
Calaveras	1/27/2023		2/7/2023	1/31/2024	2/2/2024	2/5/2024
Colusa	4/3/2023	4/4/2023	5/11/2023	3/15/2024	3/20/2024	4/2/2024
Contra Costa	1/30/2023		2/1/2023	2/13/2024	2/14/2024	2/15/2024
Del Norte	1/30/2023		2/7/2023	1/30/2024	1/31/2024; 2/1/24	2/5/2024
El Dorado	2/24/2023		2/28/2023	1/30/2024	1/30/2024	1/30/2024
Fresno	1/31/2023	2/2/2023	2/10/2023	1/29/2024	1/30/2024	2/1/2024
Glenn	12/14/2023	12/21/2023	2/16/2024			
Humboldt	1/31/2023		2/2/2023	1/30/2024	1/31/2024	2/2/2024
Imperial	1/20/2023	1/23/2023	2/1/2023	1/19/2024	1/24/2024; 1/30/24	2/7/2024
Inyo	5/19/2023		8/16/2023			
Kern	1/31/2023	2/1/2023	2/15/2023	2/2/2024	2/9/2024	2/23/2024
Kings	1/10/2023	1/19/2023	2/14/2023	2/8/2024	2/14/2024	2/16/2024
Lake	1/31/2023		2/1/2023			
Lassen	2/8/2023	2/9/2023	2/14/2023	2/29/2024	2/29/2024	3/5/2024
Los Angeles	1/31/2023	2/2/2023	2/17/2023	2/5/2024	2/6/2024	2/16/2024
Madera	2/8/2023	2/9/2023	2/14/2023	3/22/2024		3/29/2024
Marin	1/30/2023	1/31/2023	2/3/2023	1/31/2024	2/2/2024	2/5/2024

DHCS Status Chart of County RERs Received
May 23, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Mariposa	4/19/2023	4/20/2023	4/21/2023	2/7/2024	2/15/2024	2/15/2024
Mendocino	1/31/2023		2/2/2023	1/31/2024	2/5/2024	2/15/2024
Merced	1/19/2023		1/23/2023	1/18/2024	1/19/2024	1/23/2024
Modoc	3/23/23	4/4/2023	4/5/2023			
Mono	1/31/2023		2/2/2023	1/31/2024	2/5/2024	
Monterey	1/31/2023	2/2/2023	2/2/2023	1/31/2024	2/1/2024	2/6/2024
Napa	1/31/2023	2/1/2023	2/13/2023	2/6/2024	2/9/2024	3/11/2024
Nevada	1/31/2023	2/1/2023	2/2/2023	1/31/2024	2/9/2024	2/14/2024
Orange	1/31/2023		2/1/2023	1/31/2024	2/7/2024	2/15/2024
Placer	1/31/2023	2/1/2023	2/14/2023	1/31/2024	n/a	2/7/2024
Plumas	2/14/2023	2/15/2023	2/21/2023	2/9/2024	2/9/2024	2/15/2024
Riverside	1/31/2023	2/1/2023	2/15/2023	2/1/2024	2/8/2024	2/21/2024
Sacramento	1/25/2023	1/26/2023	1/27/2023	1/31/2024	2/14/2024	2/23/2024
San Benito	5/10/2023	5/11/2023	5/25/2023	3/18/2024	3/18/2024	3/22/2024
San Bernardino	1/31/2023		2/6/2023	1/31/2024	2/12/2024	2/21/2024
San Diego	1/31/2023	1/31/2023	2/14/2023	1/30/2024	2/5/2024	2/14/2024
San Francisco	1/31/2023	2/1/2023	2/16/2023	1/31/2024	2/8/2024	
San Joaquin	1/31/2023		2/1/2023	2/22/2024	3/7/2024	3/27/2024
San Luis Obispo	12/30/2023	1/6/2023	1/19/2023	1/25/2024	2/8/2024	2/14/2024
San Mateo	3/6/2023	3/24/2023	4/3/2023	2/16/2024	2/22/2024	4/9/2024
Santa Barbara	12/23/2023	2/7/2023	2/15/2023	1/30/2024	2/9/2024	2/12/2024
Santa Clara	1/31/2023	1/31/2023	2/16/2023	2/1/2024	2/15/2024	2/22/2024
Santa Cruz	4/6/2023	4/14/2023				
Shasta	1/31/2023	2/2/2023	2/16/2023	1/30/2023	2/15/2024	2/21/2024
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024

DHCS Status Chart of County RERs Received
May 23, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		4/2/2024
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023			
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	5/1/2024
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023	4/4/2024	4/5/2024	4/19/2024
Total	**57**	**42**	**57**	**50**	**47**	**50**

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Calendar (Tentative)

Focus areas are identified through the Commission's Strategic Plan goals and objectives. The 2024-2027 goals include: Champion Vision into Action, Catalyze Best Practice Networks, Inspire Innovation and Learning, and Relentlessly Drive Expectations.

The Commission's 2024-27 North Star priority is to accelerate system-level improvements to achieve early, effective, and universally available services. This priority will guide the evolution and design of the Commission's initiatives and projects, further informed by three more clearly defined operational priorities: (1) Build foundational knowledge, (2) Close the gap between what is being done and what can be done, and (3) Close the gap between what can be done and what must be done.

The draft calendar below reflects efforts to align the Commission meeting focus areas with priorities outlined in the 2024-2027 Strategic Plan. **All topics and locations subject to change**.

Dates	Locations	Focus Areas*
July 25	Sacramento	Fiscal Transparency and Accountability in BHSA Substance Use Disorder and Mental Health Integration Early Psychosis Strategic Plan
August 22	San Diego	Housing and Behavioral Health Services Panel Universal Screenings Draft Report Rural County Perspectives and Needs
September 26	Sacramento	Behavioral Health Workforce Strategies Psychiatric Advanced Directives Report Out Research Agenda
October 24	Sacramento	Community Engagement Planning Master Plan on Aging Implementation
November 21	Los Angeles	Strategic Plan Report Out Behavioral Health Reform Progress Report

*NOTE: The priorities listed are not the only agenda items under consideration for each month.