WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
Day 1

January 25, 2023
2:00 – 5:00 PM

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA (Two-Days)

JANUARY 25, 2023 - JANUARY 26, 2023

NOTICE IS HEREBY GIVEN that the Mental Health Oversight and Accountability Commission will conduct a Regular Meeting on **January 25, 2023 and January 26, 2023.** This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123 and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at these public meeting as described in this Notice.

Dates: January 25, 2023 – DAY 1
January 26, 2023 – DAY 2

Times: DAY 1: 2:00 PM – 5:00 PM
DAY 2: 9:00 AM – 3:00 PM

Location: Mission Inn Riverside
3649 Mission Inn Avenue
Riverside, CA 92501

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

Our Commitment to Excellence

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

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

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Agenda

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

JANUARY 25, 2023 — DAY ONE

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/81627108301
Meeting ID: 816 2710 8301

FOR PHONE DIAL IN
Dial-in Number: 1-408-638-0968
Meeting ID: 816 2710 8301

2:00 PM

1. **Call to Order & Roll Call**
   Chair Mara Madrigal-Weiss will convene the Commission meeting.

2:05 PM

2. **Announcements & Committee Updates** *Information*
   The Commission will make announcements, share updates and welcome *Matthew Chang, M.D., MMM, Riverside University Health System-Behavioral Health Director*.

2:25 PM

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

2:50 PM

4. **November 17, 2022 Meeting Minutes** *Action*
   The Commission will consider approval of the minutes from the November 17, 2022 Commission Meeting.
   - Public Comment
   - Vote

3:00 PM

5. **Consent Calendar** *Action*
   All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

Semi Statewide Electronic Enterprise Health Record Innovation project (eight Counties).

County	Total Innovation Funding Request	Duration of Innovation Project Years
Imperial	$2,974,849	5
Kings	$3,203,102	5
Mono	$986,403	5
Placer	$4,562,393	5
San Benito	$4,940,202	5
San Joaquin	$8,748,140	5
Siskiyou	$1,073,106	5
Ventura	$3,514,910	5
Total	**$30,003,105.00**	

- Public Comment
- Vote

3:10 PM

6. **Full Service Partnership Report** *Action*

The Commission will receive a presentation and consider adoption of the Full Service Partnership Report as required under Welfare and Institutions Code section 5845.8 (SB 465); *presented by Melissa Martin-Mollard, Ph.D., Director of the Research and Evaluation Division.*

- Public Comment
- Vote

3:40 PM

7. **Santa Barbara Innovation Project** *Action*

The Commission will consider approval of $7,552,606 in innovation funding for Santa Barbara County's Housing Retention and Benefit Acquisition innovation project; *presented by Natalia Rossi, JD., MHSA Manager, Santa Barbara County Department of Behavioral Wellness.*

- Public Comment
- Vote

4:05 PM

8. **Alameda Innovation Projects** *Action*

The Commission will consider approval of two Alameda County innovation projects: (1) $8,692,893 in innovation funding for Peer-Led Continuum for Forensics and Re-entry Services and (2) $13,432,651 in innovation funding for Alternatives to Confinement; *presented by Roberta Chambers, PsyD., Consultant, Indigo Project.*

- Public Comment
- Vote

4:30 PM

9. **The Governor's 2023-2024 Proposed Budget and the Commission's 2022-2023 Mid-Year Budget Report & Expenditure Authority** *Action*

The Commission will be presented with the Governor's 2023-2024 Proposed Budget as it relates to Mental Health, a mid-year update of the Commission's 2022-2023 expenditures, and consider approving new expenditures; *presented by, Norma Pate, Deputy Director.*

- Public Comment
- Vote

5:00 PM

10. **Recess**

The Commission will recess for the day and reconvene this meeting on January 26, 2023 at 9:00 a.m.

Mental Health Services
Oversight & Accountability Commission

JANUARY 26, 2023 — DAY TWO

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/88564029746
Meeting ID: 885 6402 9746

FOR PHONE DIAL IN
Dial-in Number: 1-408-638-0968
Meeting ID: 885 6402 9746

9:00 AM

1. **Call to Order & Introductory Comments**
   Chair Mara Madrigal-Weiss will re-convene the Commission meeting from January 25, 2023.

9:15 AM

2. **The Commission's 2020-23 Strategic Plan** *Information*
   The Commission will receive an overview of its 2020-2023 Strategic Plan including accomplishments, current projects and opportunities for 2023; *presented by Commissioners and Commission Staff.*
   - Public Comment

11:45 AM

3. **Working Lunch**
   Commissioners will take a short break and receive an Overview of Opportunities Going Forward; *presented by Chair Mara Madrigal-Weiss.*

12:30 PM

4. **The Commission's 2023 Priorities** *Information*
   The Commission will discuss options and priorities for the final year of the 2020-2023 Strategic Plan; *presented by Toby Ewing, Executive Director.*
   - Public Comment

2:00 PM

5. **Break**

2:10 PM

6. **The Commission's 2024-2027 Strategic Plan** *Action*
   The Commission will discuss development of a 2024-2027 Strategic Plan and consider authorizing funding to retain a strategic planning consultant; *presented by Commissioners and Commission Staff.*
   - Public Comment
   - Vote

3:00 PM

7. **Adjournment**

Mental Health Services
Oversight & Accountability Commission

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

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

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

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

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

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

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

AGENDA ITEM 4

Action

January 25, 2023 Commission Meeting

Approve November 17, 2022 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the November 17, 2022 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) November 17, 2022 Meeting Minutes; (2) November 17, 2022 Motions Summary

Handouts: None.

Proposed Motion: The Commission approves the November 17, 2022 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date November 17, 2022

Time 9:00 a.m.

Location 1812 9th Street
Sacramento, California 95811

Members Participating:

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

*Participated remotely.

Members Absent:

John Boyd, Psy.D.
Sheriff Bill Brown
Assembly Member Wendy Carrillo
Senator Dave Cortese

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Melissa Martin-Mollard, Ph.D., Director, Research and Evaluation Division
Tom Orrock, Chief, Community Engagement and Grants Division
Lauren Quintero, Chief, Administrative Services
Maureen Reilly, Assistant Chief Counsel
Sharmil Shah, Psy.D., Chief, Program Operations
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:05 a.m. and welcomed everyone.

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

Amariani Martinez, Commission staff, reviewed the meeting protocols.

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

2: Announcements

Chair Madrigal-Weiss gave the announcements as follows:

- The October 2022 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on January 26th in Sacramento. *It should be noted that after Chair Madrigal-Weiss made this announcement, the date and location of the next Commission meeting was changed to January 25-26, 2023 in Riverside, California.*
- Senate Bill 465 requires the Commission to provide biennial reports to fiscal and policy legislative committees on outcomes for those individuals receiving services under a full-service partnership (FSP) model.
    - Commission staff have prepared the first of these FSP Reports, which describe the opportunity and provide a history of FSPs and the target populations they are meant to serve. The report includes an overview of the existing evidence that supports the effectiveness of FSPs and describes some of the current limitations of the data to conduct a rigorous, statewide evaluation.
    - Many of these data limitations have been highlighted by the Multi-County FSP Innovation project, the cohort of nine counties who are working to develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.
    - Commissioner Rowlett organized a meeting with FSP provider staff who provided feedback on the initial report, set up site visits to FSPs in the early part of 2023, and helped organize a panel of FSP experts for a future Commission meeting.

Executive Director Ewing thanked Chair Emeritus Lynne Ashbeck and Commissioner Emeritus Ken Berrick for their contributions and presented them with resolutions in appreciation for their years

of service with the Commission. Commissioners and members of the public congratulated them and wished them well in their future endeavors.

New Staff

Chair Madrigal-Weiss asked Lauren Quintero to share recent staff changes.

Lauren Quintero, Chief, Administrative Services, stated one new staff member has joined the Commission since the last Commission meeting. She introduced Trinie Flaggs.

On behalf of the Commission, Chair Madrigal-Weiss welcomed Trinie Flaggs to the Commission.

3: September 22, 2022, and October 27, 2022, Meeting Minutes (Action)

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the September 22, 2022, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

Public Comment. There was no public comment.

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

- *The Commission approves the September 22, 2022, teleconference Meeting Minutes as written.*

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

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

The following Commissioner abstained: Commissioner Mitchell.

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the October 27, 2022, Commission meeting.

Public Comment. There was no public comment.

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

- *The Commission approves the October 27, 2022, teleconference Meeting Minutes as written.*

Motion carried 6 yes, 0 no, and 5 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bunch, Carnevale, Chambers, Danovitch, and Tamplen, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioners Bontrager, Gordon, Mitchell, and Rowlett, and Vice Chair Alvarez.

4: General Public Comment (Information)

Miya Bray, Intern, REMHDCO, and transition age youth (TAY), stated the Client and Family Leadership Committee (CFLC) voted in favor of adopting the two recommendations to the list of prevention and early intervention (PEI) priorities set forth by the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the California Reducing Disparities Project (CRDP). Those recommendations were the addition of TAY not enrolled in college and the inclusion of community-defined evidence practices (CDEPs). The Cultural and Linguistic Competence Committee (CLCC) also voted in favor of these two recommendations in the past. The speaker stated the hope that the Commission understands the importance of these recommendations and takes them into consideration.

Matt Gallagher, Assistant Director, Cal Voices, stated concern about the lack of accessibility. He stated he has had difficulty hearing hybrid Commission meetings online and stated the hope that the Commission will look into this going forward. He stated this is a space where individuals are open and able to bring their concerns and difficulties they are seeing in their communities before the Commission. One of the Commission's obligations is to oversee the mental health system of care for prevention, intervention, adults, and children. He stated concern that communities see little oversight and accountability. That is why unmet needs persist. He stated Cal Voices brings this issue before the Commission in hopes that the Commission will do something about it.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, ACCESS California, a program of Cal Voices, stated concern that they had difficulty linking into the last CFLC meeting; the speaker was only able to access the last half-hour, but the captioning was not on. The speaker reminded the Commission that the Mental Health Services Act (MHSA) is not intended for the Community Assistance, Recovery, and Empowerment (CARE) Court.

Steve Dilley, Executive Director, The Veterans Art Project (VETART), stated there was a wonderful Pop-Up Art Café on October 13th on the left steps of the State Capital, where veterans shared their artwork, spoken word, and music to celebrate wellness to the arts. The speaker thanked the Commission for this opportunity to serve veterans with this innovative approach.

Mark Karmatz, consumer and advocate, stated a speaker at the Alternatives Conference 2022 mentioned that CARE Courts may possibly become federal law.

5: Election of the 2023 MHSOAC Chair and Vice Chair (Action)

Presenter:

- Geoff Margolis, Chief Counsel

Chair Madrigal-Weiss stated nominations for Chair and Vice Chair for 2023 will be entertained and the Commission will vote on the nominations and elect the next Chair and Vice Chair.

Geoff Margolis, Chief Counsel, briefly outlined the election process and asked for nominations for Chair of the MHSOAC for 2023.

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

- *The Commission re-elects Mara Madrigal-Weiss as Chair of the Mental Health Services Oversight and Accountability Commission for 2023.*

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

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

Mr. Margolis asked for nominations for Vice Chair of the MHSOAC for 2023.

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

- *The Commission re-elects Mayra Alvarez as Vice Chair of the Mental Health Services Oversight and Accountability Commission for 2023.*

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

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

Public Comment

Stacie Hiramoto, Director, REMHDCO, congratulated Chair Madrigal-Weiss and Vice Chair Alvarez and stated she looked forward to continuing to work with them. She noted that public comment should come prior to the vote.

6: Break

The Commission took a short break.

7: Semi-Statewide Electronic Health Record (EHR) Multi-County Innovation Project (Action)

Presenter:

- Sharmil Shah, Psy.D., Chief, Program Operations

Chair Madrigal-Weiss stated the Commission will consider approval of innovation funding for the following counties to join the California Mental Health Services Authority's (CalMHSA) Semi-Statewide Enterprise Health Record Multi-County Innovation Project:

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

Chair Madrigal-Weiss stated this item was presented at the October 27, 2022, Commission Meeting. No changes have been made. A short summary will be provided, and the project will be

offered for the Commission's consideration. Information on this Agenda Item was included in the meeting materials.

Chair Madrigal-Weiss asked staff to present this agenda item.

Sharmil Shah, Psy.D., Chief, Program Operations, provided a short summary of what was presented at the last Commission meeting. She stated Humboldt, Tulare, and Sonoma Counties are seeking approval to use innovation funds to partner with the CalMHSA on the Semi-Statewide Electronic Health Record (EHR) Innovation Project, along with approximately 20 other counties. This project is designed to effect local levels system change by creating a more integrated holistic approach to county Health Information Technology collection, storage, and reporting. The overall goal is to increase the quality of mental health services, including measurable outcomes, and promote interagency and community collaboration.

Dr. Shah stated these 23 counties are collectively responsible for approximately 4 million of the state's Medi-Cal beneficiaries. Counties have prioritized this innovation project in response to the severe behavioral health workforce challenge that they face in hopes that they can preserve the current workforce and improve the quality of services, especially during this time when mental health services are needed so desperately.

Dr. Shah stated counties have identified three key aims for the project: to reduce documentation burden by 30 percent; to facilitate cross-county learning by standardizing data collection; and to form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden. This project hypothesizes that reducing the impacts of documentation will increase provider satisfaction and employee retention and improve overall patient care and outcomes. The project will engage counties collaboratively to design a lean and modern EHR system to meet the needs of California counties. The key principles of the EHR project include: an enterprise solution, collective learning and scalable solutions, leverage California Advancing and Innovating Medi-Cal (CalAIM), be lean and human-centered, and interoperability.

Dr. Shah stated Commission staff shared this project with its six community partner contractors, its listserv, and both the CFLC and CLCC.

Commissioner Comments & Questions

Commissioner Bontrager asked if the current software meets all federal interoperability rules.

Amie Miller, Psy.D., Executive Director, CalMHSA, stated all interoperability requirements are being met.

Commissioner Bontrager asked if patients will have access to their own record.

Dr. Miller stated they will. A Patient Portal will be a part of this project native to all county users.

Commissioner Carnevale asked how this project compares to other projects in the state. A benchmarking against best practices elsewhere would be useful.

Dr. Miller stated this project is different. The innovation layer around this project is counties working together collectively. The aim of this project is to bring counties together in order to take

on more ambitious projects, achieve more, and keep up with the rapid pace of change in a way that counties would not be able to do alone.

Commissioner Carnevale asked if this project will become a pilot for other counties to follow.

Dr. Miller stated there is another cohort of counties going live in July of 2024. There are EHR practice innovations that will spread.

Public Comment

Matt Gallagher asked if this project is consistent with the Commission's goals for innovation, which will be discussed later in the agenda. He stated the proposed project does not provide greater services for Black and indigenous people of color (BIPOC) or LGBTQ communities, does not invest in crisis respite, and does not invest in providing greater services for the unhoused community. It is an investment in infrastructure, which is already required under CalAIM. There is a separate provision of the MHSA, capital needs and investments, which provides counties to do that. This project uses county innovation dollars for infrastructure, not services.

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve innovation funding for the EHR Project. Commissioner Carnevale made a motion, seconded by Commissioner Gordon, that:

- *The Commission approves innovation funding for this EHR Project in a total amount of $11,310,145.54 to be allocated among the three counties over a five-year period, as follows:*
    - Humboldt County – Up to $608,678 in MHSA INN funding for 5 Years
    - Sonoma County – Up to $4,420,447.54 in MHSA INN funding for 5 Years
    - Tulare County – Up to $6,281,021 in MHSA INN funding for 5 Years

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Mitchell and Rowlett.

8: Commission's Racial Equity Plan (Action)

Presenters:

- Anna Naify, Psy.D., Consulting Psychologist
- Lauren Quintero, Chief, Administrative Services

Chair Madrigal-Weiss stated the Commission will consider approval of the Commission's Racial Equity Plan.

Chair Madrigal-Weiss stated this item was presented at the October 27, 2022, Commission Meeting. No changes have been made. A short summary will be provided, and the project will be offered for the Commission's consideration. Information on this Agenda Item was included in the meeting materials.

Chair Madrigal-Weiss asked staff to present this agenda item.

Lauren Quintero, Chief, Administrative Services, stated Dr. Naify was unable to be in attendance today. She provided a short summary of what was presented at the last Commission meeting. Commission staff has been working with the Capitol Collaborative on Race and Equity (CCORE) and other state agencies since August 2020 and developed thoughts went into the Racial Equity Plan. Commission staff shared this project with the CFLC and CLCC. There are strategies for racial equity around commission meeting planning, diversity, equity, and inclusion in Commission staffing, grant funding, innovation, research and evaluation, policy research, and communications. She acknowledged that equity work is ongoing and that this plan is just a first step, but asked the Commission to approve this start to the Commission's racial equity work. Part of what the Commission will be asked to approve is a Racial Equity Declaration as follows:

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

Ms. Quintero stated the Racial Equity Declaration marks a commitment to the overarching goal of racial equity in California's mental health system.

Commissioner Comments & Questions

Commissioner Bunch stated disappointment that the Commission is just now getting around to this.

Ms. Quintero stated the Commission is making this explicit now due to current events, the Governor's agenda, and the CCORE cohort. The cohort helped staff know where to begin in crafting a Racial Equity Plan.

Vice Chair Alvarez stated staff met with the CLCC multiple times and took feedback from the Committee in ensuring that the plan moving forward reflected priorities from the Committee and to ensure that there is an action plan associated with the Racial Equity Plan.

Commissioner Carnevale stated the important part of this plan is that the Commission is incentivizing behavior. Incentivizing behavior and starting to drive action is how to catch up to where the Commission should already be.

Commissioner Bontrager asked what the Commission is doing to make the plan actionable.

Executive Director Ewing stated the Commission joined the second cohort of state agencies to work through this process. The plan recognizes deficits to work on and charts out a path on how to make progress. There is a lot of learning yet to do but the goal is to embed equity into all aspects of the Commission's operations. Prior to this, the Commission has been explicit in a number of ways thinking about Commission tools, such as the statewide advocacy contracts and in the Prevention and Early Intervention and Innovation Regulation data infrastructure. The Commission has done a number of things in terms of how to ensure that decisions being made

elevate equity and reductions in disparities but, as evidenced by this plan, the Commission has a long way to go.

Executive Director Ewing stated the biggest challenge is not whether or not this is important, but is the question of having clear guidance on how to move forward in a way that is aligned both with best practices in the space and with the constraints as a public agency that the Commission is required to follow. The concentration of the discussions with the process the Commission went through focused on personnel and hiring. Staff has tried to go beyond personnel and hiring to focus on procurement, research, grant making, convenings, and all of the things the Commission tries to do.

Executive Director Ewing stated this was more difficult to do during the COVID-19 pandemic. In the past, the Commission has been explicit about community engagement strategies for public forums that have had translators in four to five languages at once. He mentioned this as an expression of how hard the Commission has worked in the past in public to bring in diverse communities.

Public Comment

Matt Gallagher stated the Commission has allocated close to $7 million in innovation funds. He stated, if the Commission is truly committed to racial equity, it should look at the history of what the Commission has done, and then make steps forward to address issues. He suggested considering how much of that funding has gone to services for Black and brown communities. This may mean that the Commission needs to ask counties that come before the Commission to go back to the drawing board in order to come together with members of their Black and brown communities to develop plans to provide services to these communities. It is unclear if funding is going to serve these communities. What is heard in communities is there is a lot of talk but very little action. The best way to require action is to require that the funds be used to provide services in these communities. He asked the Commission to look into that.

Chair Madrigal-Weiss asked Executive Director Ewing to address the concerns brought to the Commission in the last public comment.

Executive Director Ewing stated the Commission does require community engagement as part of the planning process and asks questions in the analytic framework around innovation plans. In some cases, this is explicit, but it may be challenging in terms of an investment to reframe electronic health records. He highlighted that one of the most successful innovations from the perspective of its ability to scale is the Solano County innovation, where they started with an investment in understanding which communities were mostly left behind and were the least likely to access care.

Executive Director Ewing stated, through an aggressive engagement process with support from the Center for Reducing Health Disparities at UC Davis, they were able to increase participation in county programs by over 600 percent in some instances. The Commission has supported and is providing funding for an engagement process where 40 counties are now learning from the Solano County project. There is not a lot of disagreement with the concerns raised by Matt Gallagher about walking the talk. This is an example where the Commission is trying, in partnership

with county behavioral health leaders, to better understand barriers and to address those barriers and move forward in ways to see an increase in access to services, mostly because the trust between the county and the community was addressed through that engagement strategy. If this can be replicated in 40 counties, then greater impacts will be seen in areas of concern.

Stacie Hiramoto supported and thanked Matt Gallagher for his comments regarding innovations, as this component of the MHSA is one that communities of color do look to to reduce disparities. She asked the Commission to think of this plan as the floor, not the ceiling. She stated, as she mentioned at the last Commission meeting, this is not an ambitious plan. It lays out good practices that should already be taking place. REMHDCO hopes that the Commission leads the way for counties and other entities in terms of racial equity within its own workings and Commission.

Stacie Hiramoto stated it is wonderful that the Commission got input from the CLCC, but this final plan was not brought before them. She asked the Commission not to adopt this plan and then continue with business as usual, as that is not the way of the MHSA.

Stacie Hiramoto asked the Commission to remember that, although REMHDCO supports and believes strongly in the MHSA, disparities for racial and ethnic communities have not been reduced since the MHSA passed. In fact, the COVID-19 pandemic has made these disparities for BIPOC and most likely LBGTQ communities even worse. She stated Commissioner Carnevale asked what the Commission has done to promote equity. In the past, there used to be at least one cultural competence training to the Commission once a year. Equity is not just one cultural competence training per year, but one is better than none.

Stacie Hiramoto corrected the statement that the Commission was responsible for seeking funds for advocacy on behalf of racial and ethic communities in the advocacy grants. She stated her recollection that it was Rusty Selix, through the Mental Health Association, and REMHDCO who were directly responsible for the Legislature approving funds in the state budget for this purpose. The Commission may not have opposed this and may have even supported it, but it was not initiated by the Commission. That being said, REMHDCO is always willing to serve as a resource for the Commission and has always wanted to collaborate in matters of equity and reducing disparities. She wished the Commission luck in moving towards equity.

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve the Racial Equity Plan. Commissioner Tamplen made a motion, seconded by Commissioner Bunch, that:

- *The Commission approves the Racial Equity Plan.*

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

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

9: Commission's Innovation Implementation Plan (Action)

Presenter:

- Sharmil Shah, Psy.D., Chief, Program Operations

Chair Madrigal-Weiss stated the Commission will consider approval of the Commission's Innovation Implementation Plan and direct staff to seek the financial resources and additional staff necessary to carry out the Plan's recommendations.

Chair Madrigal-Weiss stated this item was presented at the October 27, 2022, Commission Meeting. No changes have been made. A short summary will be provided, and the plan will be offered for the Commission's consideration. Information on this Agenda Item was included in the meeting materials.

Chair Madrigal-Weiss asked staff to present this agenda item.

Dr. Shah provided a short summary of what was presented at the last Commission meeting. She stated she had shared about the work that has been done to understand the strengths and challenges of the innovation component, explored concerns and opportunities, and presented a plan to help counties develop transformative innovation projects, strengthen the Commission's review and approval process, and facilitate learning across and within counties.

Dr. Shah stated the Welfare and Institutions Code indicates that an innovation project could affect any part of the mental health system. She reminded everyone that, in 2020, the Commission launched a project with the nonprofit Social Finance to assess barriers to developing transformative innovations and ways the Commission can improve its process and support learning from innovation projects. This is outlined in the Innovation Action Plan, which was included in the meeting materials.

Dr. Shah stated, from an analysis of nearly 300 challenges that Social Finance found and over 100 interviews, they produced recommendations for the Commission's consideration. The Recommendation Matrix supported Commission efforts in the selection of the actions and were prioritized to achieve impact and not necessarily ease of implementation. Staff recommended a focus on a core set of these recommendations and not the full array.

Dr. Shah stated, as a result, three areas of opportunity rose to the top with specific recommended actions for each, which were included in the meeting materials and described in detail at last month's meeting: help counties develop transformative innovation projects, strengthen the Commission's review process, and facilitate learning among counties.

Dr. Shah stated Social Finance, in partnership with counties, Commission staff, and community organization, has prepared drafts of several of these documents. Based on direction from the Innovation Subcommittee in April of 2022, Commission staff have begun preparations to implement. In the next few months, staff is planning to focus on the FAQ document, the county template, and onboarding materials for both current and new Commissioners regarding the innovation component at the county level and what Commission staff can do logistically on approving innovation plans.

Dr. Shah stated, during the last five years, the Commission has worked hard with counties to build trusting relationships and uplift the importance of the innovation component as a mechanism for transformational change. Staff has considered the impact of these actions on the counties. The next phase of work will require a focus on the impact the Commission can make. Commission staff is seeking authority to move forward with these recommendations and implementation. She suggested also considering leadership, appointments, and structures for the Commission's Subcommittee on Innovation to work on the next phase of this project.

Commissioner Comments & Questions

Commissioner Bunch asked about the reasons for the recommendation in the Recommendation Prioritization Matrix to test a multi-stage approval process.

Dr. Shah stated staff is focusing on a few of the recommendations now but will revisit all the recommendations when feasible. She stated there is already a multi-tiered process that happens at the Commission staff level. Counties present their project to staff, even if it is just a paragraph. Staff provides initial feedback, asks questions, provides subject matter experts if any are known, and commits counties to those experts to flesh out the project. The county then goes back to their community, shares that information, and brings back a draft. What Social Finance was looking for was potentially involving Commissioners and other individuals in that process. Staff will have to think through what that would look like.

Commissioner Carnevale stated innovation and helping people are not mutually exclusive. In fact, innovation is essential for the Commission to help more people. There is a massive gap between what is needed for people in California and what is actually done. The Governor has done more than any in a while to drive more funding into the system to help, but it is never enough.

Commissioner Carnevale stated the economy is slowing down and more challenges will likely be seen. The only way to solve that problem is with innovation, because innovation means doing things more effectively and efficiently to help those that need it the most. He agreed with Executive Director Ewing that the only way to solve a problem is by measuring it. He stated the need to identify the data that understands how many people in what populations are not being served. The only way to do that is by investing in innovation. During the COVID-19 pandemic, doing business remotely via Zoom is an example of an innovation that helps the world serve the people who need it the most. This is a great beginning.

Dr. Shah agreed and stated innovation is about learning. There is no innovation, whether successful or unsuccessful, that cannot be learned from. That is one of the most important pieces.

Public Comment

Matt Gallagher stated, when Rusty Selix drafted the MHSA, innovation was one of the most important parts of the Act because it allowed counties to do what they could not do with their other funds. It was about finding innovative treatment models to provide individuals with the care they need to promote mental health system transformation. Unfortunately, the innovation component of the MHSA has not lived up to its expectations.

Matt Gallagher stated, after spending $700 million, it should be clear what works and what does not, there should be standard deviations for what is expected to fail in innovative programs, and, more importantly, there should be better outcomes in data. Also, the number of innovation plans that this Commission has not approved should be identified. He stated, from his perspective, it appears that the Commission is a rubber stamp for the counties where they do a bare minimum, they present it, and it is approved. Very rarely has the Commission said a proposed plan was not innovative enough and asked counties to go back to their communities to ensure it addresses unmet needs and to spend these funds more wisely.

Matt Gallagher stated counties do the best they can, but sometimes they need a little extra encouragement to do more to take it to the next level. He encouraged Commissioners to ask themselves what more they can do to expect more from counties with these plans. If counties are not expected to do more, they will not do more. Innovation is the key to systems transformation. Without new models to treatment and new and better service delivery, the necessary results will not take place on the streets and in communities.

Richard Gallo stated concern that the plans should have been monitored all along. The speaker asked why there is an oversight commission if it only selects the few without monitoring all of them. The speaker stated the need to track what is working, what can be improved, and what failed. The speaker stated the need to push the envelope with all counties. The speaker agreed with the previous speaker that the Commission is just a rubber stamp without any follow-up. All plans need to be monitored. This has been a failure and is shameful.

Stacie Hiramoto thanked the previous speakers and supported their comments. She stated she too has been disappointed with innovations, although she stated it should be acknowledged that it is difficult for counties because innovation is supposed to be funding spent on something that may not work, which is not how public money is usually spent. Innovations are meant to prove things that are not yet proven. She stated it is so difficult that many counties like to get together and join a big project, not that it is what their community has asked for but because it is easy and it is a surer thing.

Stacie Hiramoto stated it is fine to create structure in the form of committees for this project, but requested that the Commission be clear and transparent with the community about the criteria for creating a committee versus a subcommittee. A subcommittee is not subject to the rules of a committee, which is concerning. The new Children's Committee has met twice without the required membership of two consumers, two family members, and two individuals with expertise in reducing disparities.

Steve Dilley stated The Veterans Art Project, a funded statewide innovation project, has had many opportunities to learn. Clients have shared that art gives them a voice that they did not have before. The speaker at the CalVet Leadership Summit talked about the importance of upstream interventions and how access to a visual language allows for thoughts, dreams, and emotions to be expressed. Steve Dilley suggested thinking about artmaking in community that is transformational.

Commissioner Discussion

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

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

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

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

10: K-12 Student Advocacy Funding Outline (Action)

Presenter:

- Tom Orrock, Chief, Community Engagement

Chair Madrigal-Weiss stated the Commission will hear a presentation on funding for K-12 Advocacy grants. She asked staff to present this agenda item.

Mr. Orrock, Chief, Community Engagement, provided an overview, with a slide presentation, of the background, community engagement findings, K-12 students Request for Proposal (RFP) outline, local program contractor and statewide advocacy contractor responsibilities, minimum qualifications, and next steps of the K-12 Student Advocacy Contract.

Commissioner Comments & Questions

Commissioner Gordon suggested looking where possible for youth-led organizations and prioritizing the funding for support for young people to engage in the work of providing advocacy and learning how to advocate. He suggested providing stipends to youth to make it easier for them to participate.

Chair Madrigal-Weiss agreed.

Commissioner Bontrager stated the way to deliver services to children and youth is at school sites. He agreed that this would be superfluous unless the youth voice is at the center of these advocacy efforts. It is important for youth to share if the traditional notions of mental health service delivery work for them and, if not, what does work for them.

Commissioner Carnevale agreed. Student-led opportunities are great learnings for them. That is how future leaders are created in this space.

Executive Director Ewing agreed with Commissioner Gordon but stated concern that the traditional mechanisms through which the Commission shares information about a competitive procurement will not necessarily reach youth-run organizations. He asked for a motion either to move forward for staff to bring an update in three months, or to modify the proposed motion to work with a Commissioner to explore the best path to achieve the goal of focusing on youth-led organizations and ensuring that the bulk of the resources empower young people to be successful.

Commissioner Mitchell suggested taking the information to communities and schools in order to reach the students who will benefit from this level of funding. One of the challenges is the lack of information. Small organizations may never know about this grant because they are not in the information loop.

Chair Madrigal-Weiss suggested modifying the motion. She asked Commissioner Gordon to work alongside staff.

Chair Madrigal-Weiss asked Executive Director Ewing about the language for a modified motion.

Executive Director Ewing stated the motion would be to direct staff to work with Commissioner Gordon to release these funds to support K-12 advocacy through a competitive procurement, unless allowed to be released through sole-source contracting, and to do so in a way that elevates the voice of youth and supports their ability to participate in mental health advocacy aligned with school mental health.

Chair Madrigal-Weiss asked for a motion to approve the above language for K-12 Student Advocacy Funding. Commissioner Carnevale made a motion, seconded by Commissioner Bunch.

Public Comment

Richard Gallo stated concern about the minimum qualifications. The speaker stated the need for a requirement to have a person with lived experience serve these students.

Mark Karmatz stated they learned at the Alternatives Conference 2022 that the state of Oregon did something similar to this and got students active in advocacy. The speaker suggested listening to that workshop.

Cheryl Brown, Chair, Commission on Aging, spoke in support of the RFP and the modified motion. The speaker stated the need to get the word out about the RFP and suggested working with students and adults to ensure that everyone has an opportunity to participate in the process.

Steve McNally stated Sierra Health Foundation has a project addressing substance use disorders that was accepted by city councils. The speaker agreed with Cheryl Brown's comments about the need to ensure that individuals better understand the system in order to advocate for it.

Steve McNally stated, from a scalability standpoint, students have discussed the difficulty of putting clubs on campus that address suicide directly and how different districts vary in how open they are to it. The speaker stated the Commission could provide technical assistance to scale advocacy clubs on campus to reach more students. The speaker noted that clubs on campus can be done for a relatively small amount of funding.

Commissioner Discussion

Chief Counsel Margolis offered a friendly amendment to the motion as follows: The Commission directs staff to work with Commissioner Gordon to issue $2,010,000 in grants to support K-12 advocacy through a competitive process or, if allowed, through a sole-source contract.

Commissioners Carnevale and Bunch agreed to accept the friendly amendment.

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

- *The Commission directs staff to work with Commissioner Gordon to issue $2,010,000 in grants to support K-12 advocacy through a competitive process or, if allowed, through a sole-source contract.*

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

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

11: The Mental Health Awareness Act & Older Adults (Action)

Presenter:

- Susan DeMarois, Director, California Department of Aging

Chair Madrigal-Weiss stated the Commission will hear a presentation on how Mental Health Wellness Act funds can support California's Master Plan for Aging. She asked the representative from the California Department of Aging to present this agenda item.

Susan DeMarois, Director, California Department of Aging (CDA), provided an overview, with a slide presentation, of the California Master Plan for Aging, scaling best practices: the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS).

Sharon Nevins, Director, San Bernardino County Aging and Adult Services, continued the slide presentation and discussed scaling best practices: the AgeWise Program. She presented the AgeWise Program to the Commission as an effective model primed for replication throughout the state in counties of all sizes. She showed a video on the AgeWise Program.

Ms. DeMarois continued the slide presentation and discussed the MHSOAC/CDA partnership model to triple the number of PEARLS sites statewide, replicate AgeWise in at least two additional counties, partner with local Area Agencies on Aging (AAAs), and offer technical assistance and evaluation that focuses on sustainability and alignment with Medi-Cal and CalAIM.

Commissioner Comments & Questions

Chair Madrigal-Weiss asked staff to post the AgeWise video in the meeting materials. She asked Executive Director Ewing to summarize where the Commission is with this opportunity.

Executive Director Ewing stated the Mental Health Wellness Act was originally focused on supplemental staffing to behavioral health departments for crisis response. The Commission saw opportunities with multiple partners to address upstream prevention and early intervention. The Commission asked staff to research where investments were lacking. The two ends of the spectrum – very young children and older adults – had less attention than the demographics in the middle.

Executive Director Ewing stated the Commission reached out to the Department of Aging, recognizing the tremendous energy and effort that went into developing the Master Plan for Aging. He highlighted that the Commission asked staff to focus these dollars on areas of best practice interventions that can be scaled. Rather than supplementing existing funding, these

dollars would be used to shape other investments in order to be most effective in responding to the needs of California's diverse populations.

Executive Director Ewing stated, in coordination with the leadership team at the Department of Aging and building off of the community input they received, PEARLS and AgeWise were identified. He stated the Commission can move forward with the MHSOAC/CDA partnership model proposal as it is laid out and authorize staff to work with the Department of Aging to release those dollars, or the Commission can ask staff to refine the proposal and come back with a specific ask, or to explore other alternatives. The proposal would allow implementation quickly to deliver resources that would be supportive of older adult needs across the state.

Commissioner Gordon asked how counties currently sustain these programs.

Executive Director Ewing stated some of these projects have started off with innovation funds. Part of the technical assistance would be to learn how to sustain these programs.

Commissioner Carnevale stated these programs will help many individuals and will save money for the state in the long run. These services are important because they can identify issues early on with the hope that they can be addressed in order to bring in interventions that can reduce the overall impact.

Commissioner Tamplen asked about next steps.

Executive Director Ewing stated the Commission directed staff to bring forward proposals on reducing psychiatric hospitalizations, older adults, children 0-5, peer respite, and substance use disorder services. A presentation was heard at the last Children's Committee meeting on opportunities in the 0-5 space. Staff is working with Commissioners on the peer respite and substance use disorder services. In this instance, there was a tremendous benefit in that the Department of Aging was willing to share the work they have done and their lessons learned. This allowed staff to move this issue forward faster than the other topics.

Vice Chair Alvarez commended the Department of Aging's commitment to inclusion and community voice in the process of creating the Master Plan for Aging. She encouraged the Commission as it works to distribute these resources to keep that commitment alive, especially the data that was shared about the increasing diversity of the older community and being responsive to the specific needs of California's diverse communities, and the opportunity to elevate community-defined evidence-based practices and uplift the leadership and knowledge of these communities.

Public Comment

Tina Entz, San Bernardino County Department of Behavioral Health, spoke in support of the AgeWise Program.

Richard Gallo spoke in support of these programs. The speaker asked if the Mental Health Specialist and the Peer/Family positions will be paid a living wage.

Karol Swartzlander, Executive Director, Commission on Aging, spoke in support of these programs.

Cheryl Brown spoke in support of these programs. The speaker stated the need to provide community awareness of these programs.

Mark Karmatz stated they will send information to staff on a workshop presented at a recent conference.

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve partnering with the Department of Aging. Commissioner Carnevale made a motion, seconded by Commissioner Rowlett, that:

- *The Commission approves partnering with the California Department of Aging, and authorizes the expenditure of $20 million of Mental Health Wellness Act funding to elevate, scale, and provide technical assistance for the PEARLS and AgeWise Programs.*

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

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

12: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on January 26, 2023. There being no further business, the meeting was adjourned at 1:04 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 1

Date: November 17, 2022

Proposed Motion:
That the Commission approves the September 22, 2022 Commission Meeting Minutes

Commissioner making motion: Commissioner Bontrager

Commissioner seconding motion: Commissioner Gordon

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

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 2

Date: November 17, 2022

Proposed Motion:
That the Commission approves the October 27, 2022 Commission Meeting Minutes

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Carnevale

Motion carried 6 yes, 0 no, and 5 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
17. Commissioner Bontrager	☐	☐	☒	☐	☐
18. Commissioner Boyd	☐	☐	☐	☒	☐
19. Commissioner Brown	☐	☐	☐	☒	☐
20. Commissioner Bunch	☒	☐	☐	☐	☐
21. Commissioner Carnevale	☒	☐	☐	☐	☐
22. Commissioner Carrillo	☐	☐	☐	☒	☐
23. Commissioner Chambers	☒	☐	☐	☐	☐
24. Commissioner Chen	☐	☐	☐	☐	☒
25. Commissioner Cortese	☐	☐	☐	☒	☐
26. Commissioner Danovitch	☒	☐	☐	☐	☐
27. Commissioner Gordon	☐	☐	☒	☐	☐
28. Commissioner Mitchell	☐	☐	☒	☐	☐
29. Commissioner Rowlett	☐	☐	☒	☐	☐
30. Commissioner Tamplen	☒	☐	☐	☐	☐
31. Vice-Chair Alvarez	☐	☐	☒	☐	☐
32. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 3

Date: November 17, 2022

Motion:
The Commission re-elects Chair Mara Madrigal-Weiss as Chair of the Mental Health Services Oversight and Accountability Commission for 2023.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Vice Chair Alvarez

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

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 4

Date: November 17, 2022

Motion:
The Commission re-elects Vice-Chair Mayra Alvarez as Vice-Chair of the Mental Health Services Oversight and Accountability Commission for 2023.

Commissioner making motion: Chair Madrigal-Weiss

Commissioner seconding motion: Commissioner Bunch

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

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

Motions Summary
November 17, 2022

Motion #: 5

Date: November 17, 2022

Proposed Motion:
That the Commission approves innovation funding for this EHR Project in a total amount of $11,310,145.54 to be allocated among the three counties over a five-year period, as follows:

- Humboldt County – Up to $608,678 in MHSA INN funding for 5 Years
- Sonoma County – Up to $4,420,447.54 in MHSA INN funding for 5 Years
- Tulare County – Up to $6,281,021 in MHSA INN funding for 5 Years

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Gordon

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 6

Date: November 17, 2022

Proposed Motion:
That the Commission approves the Racial Equity Plan.

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Commissioner Bunch

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

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 7

Date: November 17, 2022

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

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Tamplen

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

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 8

Date: November 17, 2022

Motion:
That the Commission directs staff to work with Commissioner Gordon to issue $2,010,000 in grants to support K-12 advocacy through a competitive process or, if allowed, through a sole-source contract.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Bunch

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

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

Motions Summary
Commission Meeting
November 17, 2022

Motion #: 9

Date: November 17, 2022

Proposed Motion:
The Commission approves partnering with the California Department of Aging, and authorizes the expenditure of $20 million of Mental Health Wellness Act funding to elevate, scale, and provide technical assistance for the PEARLS and AgeWise Programs.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Rowlett

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

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

AGENDA ITEM 5

Action

January 25, 2023 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of the Consent Calendar which contains eight Innovation Funding Requests.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar Items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

The following counties have requested to join the Commission-approved **Semi-Statewide Enterprise Health Record** Innovation Project:

County	Total INN Funding Requested	Duration of INN Project (years)
Imperial	$2,974,849	5
Kings	$3,203,101.78	5
Mono	$986,402.89	5
Placer	$4,562,393	5
San Benito	$4,940,202	5
San Joaquin	$8,748,140	5
Siskiyou	$1,073,106	5
Ventura	$3,514,910	5

Semi-Statewide Enterprise Health Record Innovation Project

Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura counties are seeking approval to use INN funds to partner with California Mental Health Services Authority

(CalMHSA) on the Semi-Statewide Enterprise Health Record Innovation Project (hereafter referred to the EHR Project) along with approximately 15 other counties.

Tulare County was previously approved by the Commission in June 2022 to utilize up to$1,000,000 in Innovation funding for Phase 1 planning of this project and on November 17, 2022, the Commission approved Humboldt, Sonoma, and Tulare (Phase 2-Implementation) counties to launch the EHR Project.

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

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

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

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

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

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

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

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

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

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

Consistent with the five key principles identified above, this project will result in an enterprise software solution that supports county business needs and EHR management, and will facilitate data sharing.

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

Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura counties have requested to join the EHR Project and that the Commission authorize up to $30,003,104.67 in Mental Health Services Act Innovation funds over five years for their participation in the EHR Project.

Enclosures (2): (1) Commission Community Engagement Process; (2) Semi-Statewide Enterprise Health Record Staff Analysis

Additional Materials (1): A link to the Semi-Statewide Enterprise Health Record Innovation Project final plan is available on the Commission website at the following URL:

Multi-County_INN-Plan_EHR-Statewide_12222022_final.pdf (ca.gov)

Proposed Motion: That the Commission approves Agenda Item 5 as described above.

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

STAFF ANALYSIS

SEMI-STATEWIDE ENTERPRISE HEALTH RECORD INNOVATION PROJECT

Innovation (INN) Project Name: **Semi-Statewide Enterprise Health Record Innovation Project**

Collaborating Counties: **Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura (cohort two)**

Total INN Funding Requested: **Up to $ 30,003,104.67**

Duration of INN Project: **5 years**

MHSOAC consideration of INN Project: **January 25, 2023**

Review History:

County	Total INN Funding Requested	Duration of INN Project (years)	MHB	BOS	30-day Public Comment
Imperial	$2,974,849	5	12/15/2022	01/13/2023	11/15-12/15/22
Kings	$3,203,101.78	5	09/26/2022	10/04/2022	08/24-09/24/22
Mono	$986,402.89	5	10/17/2022	10/18/2022	09/18-10/17/22
Placer	$4,562,393	5	09/26/2022	09/27/2022	08/26-09/26/22
San Benito	$4,940,202	5	10/20/2022	11/22/2022	09/15-10/20/22
San Joaquin	$8,748,140	5	09/21/2022	10/04/2022	08/22-09/21/22
Siskiyou	$1,073,106	5	10/03/2022	10/18/2022	09/03-10/03/22
Ventura	$3,514,910	5	10/17/2022	11/1/2022	09/19-10/17/22

Project Introduction: Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura Counties are seeking approval to use innovation funds to partner with CalMHSA on

the Semi-Statewide Enterprise Health Record Innovation Project (hereafter referred to as the EHR Project) along with approximately 15 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting, with the goal to **increase the quality of mental health services, including measurable outcomes and promote interagency and community collaboration.** Together, these 23 counties are collectively responsible for 4,000,000 (27%) of the state's Medi-Cal Beneficiaries.

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

Tulare County was previously approved by the Commission in June 2022 to utilize up to $1,000,000 in INN funding for Phase 1 planning of this project and on November 17, 2022, the Commission approved Humboldt, Sonoma and Tulare (Phase 2-Implementation) counties to launch the EHR Project.

Identified Need

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

Imperial County reports that they implemented their first electronic health record in 2003 in response to the state mandate. While the county explains that the system was innovative at the time, national standards for health information exchanges were released a year later and they have been problem-solving and creating work arounds to meet evolving needs ever since.

Imperial reports the following issues with local use of the current EHR:

- inability for health information exchange,
- complexity of data entry forms that required too many clicks for completion,
- the need for additional applications to communicate about client care,
- complexity of modules that require entering information twice,
- the use of a platform (Java) that is no longer secured and which will not be supported going forward.

Kings County Behavioral Health conducted a community planning survey to assess the perspective of stakeholders utilizing the current EHR system and identified some challenges, including:

- "Pulling data specific to the reports I need is very difficult."
- "The system is not easy to navigate, and it does not flow well."

- "It's too outdated and it can make doing a simple task less timely and tedious than that of a more modernized EHR."

In addition, sixty-eight (68) percent of clients and providers in the county surveyed reported that the challenges of the current EHR system could cause, or have caused, user Client and Provider burnout. The survey also indicated that the current EHR system detracts from direct service time with clients and family members.

Mono County seeks to join the EHR Project to create an intuitive and easy to use system to minimize administrative burden, help increase access to providers and help retain staff who struggle with the required paperwork in the existing system. In addition, Mono County seeks to join the EHR Project to meet CalAIM requirements that they currently cannot meet.

Mono County has been working towards a new EHR system for two years because of the barriers faced when using the current legacy system. These barriers include staff reports that they spend an extra four to five hours per week spent on paperwork. The County has also struggled with significant staff vacancies that contribute to the burden faced by existing staff and create the need for innovative solutions to attract new staff and retain existing staff. Mono County hopes the new EHR will be part of the solution.

Placer County has also struggled with hiring and retaining staff with a current 14% vacancy rate in behavioral health positions in the Adult System of Care and a 9% vacancy rate in the Children's System of Care. The County identified staff frustrations which include inefficient workflows and excessive paperwork as contributing to workforce retention issues. While vacancies increased, Medi-Cal enrollment also increased creating more work for less staff. The County hopes that a new EHR system will reduce administrative time and improve retention rates.

San Benito County also struggles with employee vacancies and retention. The County further identifies that their current EHR system is outdated and not aligned with upcoming CalAIM requirements which will especially impact their Children's system of care if not addressed. The current system is not client centered and because it uses both electronic and paper records, data collection is difficult and time consuming.

San Benito County hopes that this project will allow their system to be more human centered and focus on a consumer-friendly approach to care along with developing a more effective public mental health workforce within their community.

San Joaquin County reports similar barriers such as a lack of coordination across programs, inefficient data collection options, and a lack of communication portals. The county also hopes to see some system improvements including a need to make the system user friendly, and an overall need for an EHR that serves the complete system of care in an integrated way.

Siskiyou County utilized a community planning process to identify EHR system improvement needs. Participants identified similar issues to other counties including contributions to staff burn out from poor caseload management, an inefficient documentation process, difficulty learning the current EHR, the system detracts from client care, there are needless barriers, a lack of access to the full client chart at one time and no client access to their own information.

Ventura County reports that their current EHR system is inefficient in several areas including: workflow, which is disruptive to client care, increases in user burden and stress, does not provide essential outcome criteria, does not have mechanisms in place to easily identify the need to transition clients to the most appropriate services based upon their current need, requires a significant amount of time to input information into the EHR and is not necessarily meaningful to the clients or staff, and does not meet the new CalAIM requirements.

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

CalMHSA highlights three ongoing difficulties:

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

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

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

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

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

properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities shouldered by BHPs.

How this Innovation project addresses this need

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

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

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

The project identifies three key aims:

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

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

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

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

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

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

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

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

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

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

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

Discussion of County Specific Regulatory Requirements (see Appendices, pgs. 14-157)

Imperial County held their 30-day Public Comment Period November 15, 2022 through December 15, 2022 followed by their public hearing by the local Mental Health Board on December 15, 2022 and expect County Board of Supervisors' approval on January 13, 2023.

Imperial County discussed the opportunity to join the EHR Project with the Imperial County Behavioral Health Advisory Board and conducted a stakeholder survey in September 2022. The County also discussed the EHR Project with the Consumer and Family Member Sub Quality Improvement Committee and the MHSA Steering Committee in October 2022. Through the meetings and survey, the County concluded that the need for a new EHR was clear, and that the community was in support of the Innovation opportuning present by CalMHSA. Specifically, the County reports that stakeholders are hopeful that this innovation increases the quality of care provided to clients, is more user friendly and increases ease of access to information, including through an improved client portal.

Kings County held their 30-day Public Comment Period August 24, 2022 through September 24, 2022, followed by a public hearing by the local Mental Health Board July September 26, 2022 and County Board of Supervisors' approval on October 4, 2022.

The decision to join the EHR project was made after a community planning process that began in August 2022 with discussions between the county and a variety of community partners, including the Kings County Behavioral Health Leadership Steering Committee, and a Stakeholder Focus Group facilitated at the King's County Quality Improvement Committee. The community planning process identified current EHR problems and the need for an EHR Innovation project to coincide with CalAIM launch in Calendar Year 2023. Please see pages 47-49 for a detailed list of needed system improvements identified through the planning process.

Mono County held their 30-day Public Comment Period September 18, 2022 through October 17, 2022, followed by a public hearing by the local Mental Health Board October 17, 2022 and County Board of Supervisors' approval on October 18, 2022.

Mono County began seeking community feedback on a new EHR in 2020 and worked with their Behavioral Health Board throughout 2021 and 2022 on potential EHR solutions.

During this same period, a client, and a family member of a client shared concerns about the turnover that Mono County Behavioral Health has been experiencing over the last two years and reported some lack of care coordination related to these vacancies. Mono County reports these same concerns outlined in their community survey with participants regularly citing "lack of access to mental health providers" as a top three, key challenge across age groups. The County believes that the need for an improved EHR system impacts the provider shortage that they are experiencing.

Placer County held their 30-day Public Comment Period August 26, 2022 through September 26, 2022, followed by a public hearing by the local Mental Health Board on September 26, 2022 and County Board of Supervisors' approval on September 27, 2022.

The decision to join the EHR project was made after a community planning process that included consultation with the MHSA Stakeholder Advisory Group and multiple committee meetings. Community members identified many challenges with the current system: poor user interface, lack of consumer portal, clunky provider portal with limited use (authorizations only), loss of functionality for the SUDs programs due to inadequate privacy and security issues, inability to display pertinent information at a glance, limited dashboard capabilities for outcomes and compliance monitoring, incompatible interfaces cause coding issues and systems to crash, and inability to share data electronically.
Please see pages 77-79 for a detailed list of committees and meetings where feedback on the EHR project was solicited.

San Benito County held their 30-day Public Comment Period September 15, 2022 through October 20, 2022, followed by a public hearing by the local Mental Health Board October 20, 2022 and County Board of Supervisors' approval on November 22, 2022.

The decision to join the EHR project was made after a community planning process that included discussions at Quality Improvement and Quality Leadership meetings attended by community partners and members. In addition, the EHR project was discussed at management meetings and behavioral health meetings.

San Joaquin County held their 30-day Public Comment Period August 22, 2022 through September 21, 2022, followed by a public hearing by the local Mental Health Board September 21, 2022 and County Board of Supervisors' approval on October 4, 2022.

The decision to join the EHR project was made after a community planning process that included EHR discussions at multiple meetings of the MHSA Consortium of Providers (CBO's), Consumer/Family Member Stakeholders, Behavioral Health Managers and Supervisors and the Behavioral Health Board.

In addition to meetings, San Joaquin County issued a MHSA Stakeholder Survey where more than 41% of respondents said that they spend more than 40% of work time to document in the current EHR Systems. Additional survey responses are provided on pages 95-96.

Siskiyou County held their 30-day Public Comment Period September 3, 2022 through October 3, 2022, followed by a public hearing by the local Mental Health Board October 3, 2022 and County Board of Supervisors' approval on October 18, 2022.

The decision to join the EHR project was made after a community planning process that included four meetings with community partners and two MHSA stakeholder surveys which resulted in the identified needs discussed above. Siskiyou's community is in support of participating in this project.

Ventura County held their 30-day Public Comment Period September 19, 2022 through October 17, 2022, followed by a public hearing by the local Mental Health Board October 17, 2022 and County Board of Supervisors' approval on November 1, 2022.

Ventura County initially considered participating in the EHR Project because of changes being made through CalAIM and subsequently learned of significant community interest in improving the EHR system through a department wide survey and key community partner interviews. A summary of recommendations for the new EHR system are provided on page 150.

Community Partner Feedback

This project was shared with community partners and both the Client and Family Leadership and Cultural and Linguistic Competence Committees on May 18, 2022, July 6, 2022, September

27, 2022 and October 12, 2022 when the first cohort of counties requested approval to join the collaborative.

The EHR Project was shared again on December 6, 2022 when Kings, Imperial, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura Counties submitted their appendices and request to join the collaborative.

In response, a comment was received from a member of the Client Family Leadership Committee (representing family members) on December 16, 2022, summarizing the project and providing their support for this project.

Learning Objectives and Evaluation:

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

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

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

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

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

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

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

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

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

The Budget

Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura Counties are requesting authorization to spend collectively up to $30,003,104.67 in MHSA Innovation funding for this project over a period of five (5) years.

Humboldt, Sonoma and Tulare (Phase 1 and Phase 2) Counties were previously approved to spend up to $12,310,146.54 to launch the project.

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

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	CalMHSA	Evaluation	Sustainability Plan (Y/N)
Imperial	$2,974,849	$718,744	$2,256,105	$150,000 (5%)	Y
Kings	$3,203,101.78	$1,802,706.08	$1,250,395.7	$150,000 (4.7%)	Y
Mono	$986,402.89	$317,350	$669,052.89	$150,000 (15%)	Y
Placer	$4,562,393	$1,199,845	$3,362,548	$250,000 (5%)	Y
San Benito	$4,940,202	$3,785,392	$1,154,810	$150,000 (3%)	Y
San Joaquin	$8,748,140	$744,978	$8,003,162	$500,000 (5.7%)	Y
Siskiyou	$1,073,106	$92,311	$980,795	$150,000 (13.9%)	Y
Ventura	$3,514,910	$917,284	$2,597,626	$500,000 (14%)	Y
Total Requested	**30,003,104.67**				

Innovation Total (including cohort one approvals)	$42,313,251.21

Sustainability and Dissemination (see Appendices, pgs. 14-157)

Each county has outlined how they will share the lessons learned from this investment and how they will continue to fund the new EHR system if the project is successful.

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

AGENDA ITEM 6

Action

January 25, 2023 Commission Meeting

Full Service Partnership Report to the Legislature

Summary: The Mental Health Services Oversight and Accountability Commission will consider whether to approve the initial report to the legislature on Full Service Partnerships.

Background: Full Service Partnerships 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. Several converging factors have prompted policy makers to raise concerns that California's investments in Full Service Partnerships may not be adequate to meet California's needs, including: state and communities struggling with 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; and ongoing reliance on local law enforcement programs and community hospital care as mental health peers cycle in and out of emergency departments.

In October 2021, Governor Newsom signed legislation directing California's Mental Health Services Oversight and Accountability Commission to provide biennial reports to the Legislature on the operations of Full Service Partnerships and make recommendations on fortifying state and community response to the needs of Californians who can benefit from these programs.

By approving the initial FSP report to the legislature, the Commission sets the direction for subsequent reports and supports the effort to strengthen Full Service Partnerships, including: forming an Advisory Group; identifying opportunities for capacity building; conducting a landscape analysis of Full Service Partnerships within the larger continuum of prevention, early intervention, and treatment; engaging in data quality improvement efforts with key partners; analyzing available data to understand population-level outcomes, and; providing recommendations for an investment strategy for Full Service Partnerships.

Enclosure (1): Report to the Legislature on Full Service Partnerships

Handouts (0): None

Proposed Motion: That the Commission approves the Initial Report to the Legislature on Full Service Partnerships.

Mental Health Services
Oversight & Accountability Commission

Report to the Legislature on Full Service Partnerships - Draft

By the Mental Health Services Oversight and Accountability Commission Submitted to the Fiscal and Policy Committees of the Legislature

January 2023

Mental Health Services
Oversight & Accountability Commission

Table of Contents

Executive Summary

Biennial reporting on Full Service Partnership (FSP) programs is required under Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021). This first report provides an overview of California's deployment of FSP programs established under the Mental Health Services Act and outlines the steps the Mental Health Services Oversight and Accountability Commission has underway to strengthen the use of these programs in response to high numbers of mental health consumers who are struggling with housing, justice involvement, and hospitalization.

Early evidence on the effectiveness of FSPs suggests that these programs, when implemented with fidelity, can reduce hospitalizations, criminal justice contacts, and improve housing stability for consumers with severe and persistent mental illness. However, California is experiencing an increase in the number of individuals with unmet mental health needs who are unhoused, revolving in and out of hospital emergency departments and the criminal justice system, and often deemed incompetent to stand trial and committed to state hospitals.

In its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing number of Californians with serious and persistent mental health needs that are going unmet.[1]

Recognizing the potential of FSPs to be a critical component of the State's response to those unmet needs, the Commission gathered information on the history and purpose of FSPs, reviewed the evidence base of their effectiveness, conducted an initial analysis of available statewide FSP data, and mapped the alignment of the reporting requirements outlined in SB 465 with existing quality improvement efforts across the state, particularly through

[1] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

innovation efforts supported by county behavioral health leaders.

This initial exploration and analysis revealed three primary concerns:

1. The State faces data quality challenges that impede its capacity to fully understand the effectiveness of FSPs in preventing homelessness, justice involvement, and hospitalization.
2. Despite regulatory requirements, counties do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3. California has not established sufficient technical assistance and support to ensure the effectiveness of FSP programs and support improved outcomes.

Given these challenges and the importance of FSPs in the continuum of treatment services within California for some of the most vulnerable individuals with mental health needs, the Commission submits this initial report to the Legislature, including a set of recommendations for next steps.

Background and Purpose

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 severe mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. 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 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 goal of developing a partnership between the person being served and the service provider, and offering a full

array of services, through a "whatever it takes" approach to meeting needs – or Full Service. 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 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.

Several converging factors have prompted policy makers to raise concerns that California's investments in FSPs may not be adequate to meet the growing need. These include:

- State and communities struggling with 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.

Relevant Legislation

In October 2021, Governor Newsom signed legislation directing California's Mental Health Services Oversight and Accountability Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on fortifying state and community response to the needs of Californians who can benefit from these programs (SB 465, Eggman, Chapter 544, Statutes of 2021). Welfare and Institutions Code Section 5845.8 states that the Commission's reports shall include:

- Information regarding individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room utilization, and crisis service utilization.

- Analyses of separation from a FSP and the housing, criminal justice, and hospitalization outcomes for the 12-months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

In September 2022, the Legislature passed, and Governor Newsom signed, the Community Assistance, Recovery and Empowerment (CARE) Act (SB 1338, Umberg, Chapter 319, Statutes of 2022), establishing a framework to improve access to mental health services for persons who are untreated, undertreated, or unstably housed and experiencing schizophrenia spectrum and other psychotic disorders. The framework begins with establishing a mechanism for mental health consumers and counties to negotiate individualized service plans – called CARE plans - with the courts serving as an oversight entity and authorized to compel county participation in those plans. While mental health peers and their allies have raised concerns that the CARE Act could be implemented in a coercive manner, the intent is for the Act to lead to improved access to and engagement in care. Recognizing that FSPs are intended to serve individuals who are at risk of homelessness, criminal justice involvement, and with a history of hospitalizations, the CARE Act is expected to increase demand for FSP services. For example, the development of Individual Service and Support Plans – comparable to the newly required CARE Plans – are a required component of Full Service Partnerships.

In response to SB 465 and the likelihood that the CARE Act will increase the need for effective FSP services, the Commission's goals are to improve understanding of how FSPs operate,

how they can best serve mental health consumers, and highlight strategies to reduce unnecessary participation in the CARE Act process because there is more access to quality FSPs. These efforts are intended to improve the effective use of limited public sector mental health funding, reduce costs, and improve outcomes for mental health consumers and their families.

History

In November 2004, California voters passed Proposition 63 and enacted the Mental Health Services Act (MHSA). The MHSA established new requirements for county mental health systems, including improved focus on persons with serious and persistent mental health needs, new requirements for prevention and early intervention, and a mandate for investments in innovation to drive transformational change in public mental health systems. The prevention and early intervention language of the MHSA includes an expansive focus on interrupting homelessness, criminal justice and child welfare involvement, school failure, unemployment, suicide, and prolonged suffering.

The MHSA also established a new revenue stream to support community mental health. The Act levies a 1 percent annual tax on personal income over $1 million. More than $3 billion is generated each year to fund public mental health systems and services in California.

California's investment in Full Service Partnerships (FSPs) evolved from advocacy efforts in the 1990s to reduce the number of people who were sent to locked state mental hospitals when they could be served in the community at lower cost with better outcomes. In 1999, the state passed legislation to establish four pilot projects across California to fund comprehensive and integrated care for persons with high risk for homelessness, justice involvement, and hospitalization. Early results found that program participants decreased the number of days in a hospital by 66 percent, jail

days were reduced by 82 percent, and days living unhoused by 80 percent.[2] One of the funded demonstration projects, a community program called The Village, was administered by the Mental Health Association of Los Angeles and incorporated a range of recovery principles into its work. In addition to success in reducing hospitalization, criminal justice involvement, and days unhoused, The Village was able to support employment for the clients they served.[3]

In response to these results, California expanded funding for the pilot program to include more sites around the state. Follow-up evaluations confirmed early findings: housing is a critical component of recovery; people with serious mental illness can achieve housing stability with adequate support, and consumers with the most challenges (e.g. struggling with a substance use disorder, recently incarcerated, living on the streets at enrollment, etc.) were not harder to support or keep in housing compared to mental health consumers with fewer challenges.[4]

Building off these early successes, the subsequent passage of the MHSA – and the funding it generated – created optimism that California would be able to address the needs of mental health consumers with the most complex needs without relying on long-term hospitalization, criminal justice involvement, or seeing large numbers of Californians living on the streets because of unmet mental health needs.

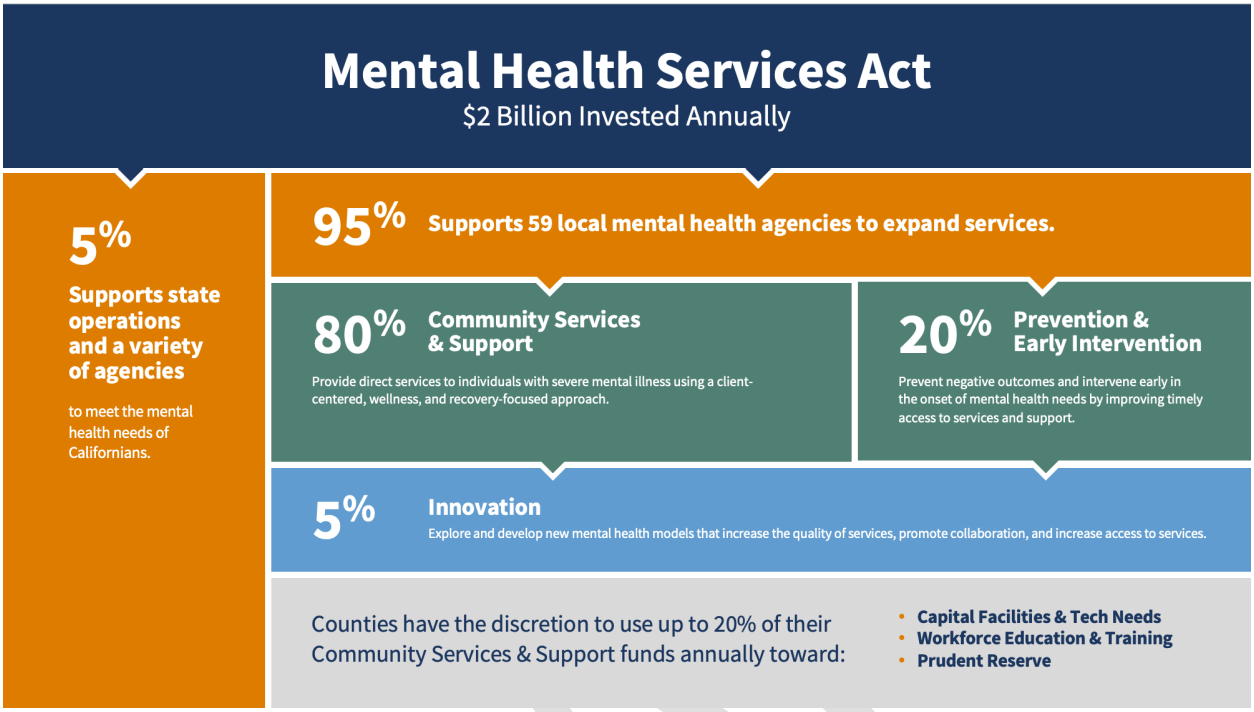
Under the MHSA, the revenues generated each year are shared between the State and California's 59 local behavioral health agencies.[5] The State receives 5 percent of MHSA revenues to fund state operations, provide grants to county behavioral health

[2] https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf
[3] http://static1.1.sqspcdn.com/static/f/1084149/15474792/1323450497457/49AnOverviewoftheVillage.pdf?token=yLvMwOUGOEYES7lmmLBuALqeTCU%3D#:~:text=The%20Village%20Integrated%20Service%20Agency%20in%20Long%20Beach%2C,system%20change.%20At%20the%20Village%2C%20we%20have%20had
[4] https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf
[5] While there are 58 counties in California, there are 59 local mental health authorities. Sutter and Yuba Counties are one entity, and the City of Berkeley and Tri-Cities are carved out from their respective counties.

departments, and to support other needs. The bulk of MHSA revenues – 95 percent – are allocated to local behavioral health agencies through a distribution formula that is largely based on the population of each local agency and the mental health needs in their communities.

Under the MHSA, local behavioral health agencies – which are typically counties – are required to distribute those funds into a minimum of three MHSA components. The largest share of the funding – 76 percent – must be dedicated to Community Services and Supports (CSS) or core mental health services for persons with more severe or serious mental health conditions. Counties are required to dedicate 19 percent of the funds they receive for prevention and early intervention activities. The balance, 5 percent of the funds, are required to support innovative efforts to improve services and outcomes. County behavioral health leaders have the option to set aside up to 20 percent of the CSS funding each year to fund a Prudent Reserve, support workforce education and training, or address capital facility and technology needs.

Figure 1: MHSA Distribution Summary

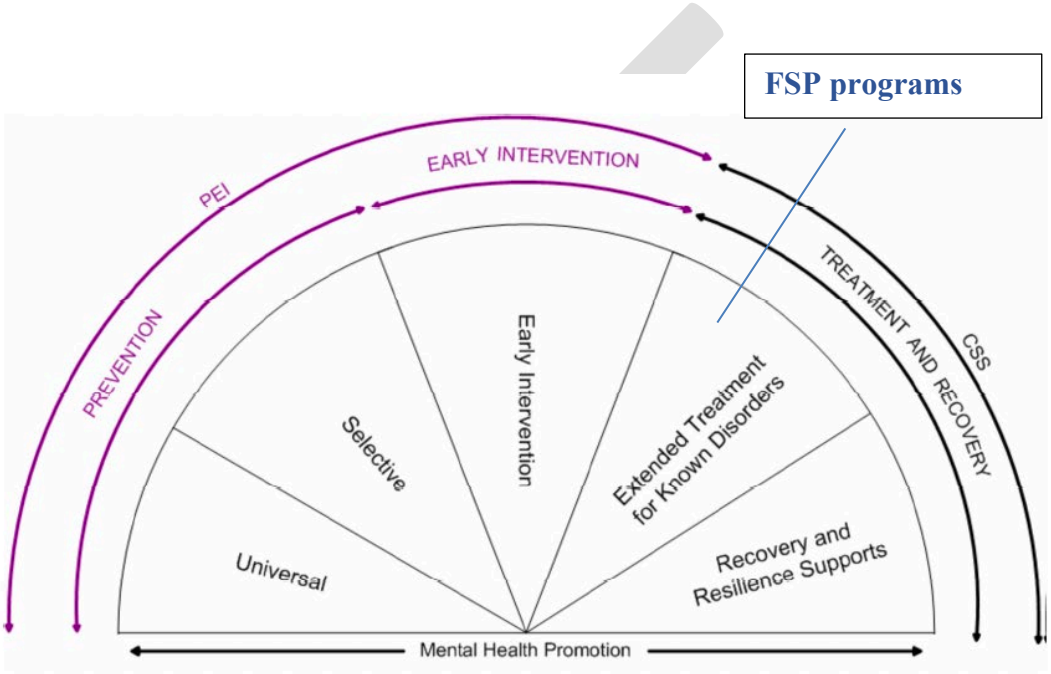


Recognizing the significance of FSPs in supporting mental health consumers with serious and persistent needs, and the focus of the MHSA on recovery, housing, and reducing criminal justice involvement, Section 3620, subdivision (c) of the MHSA regulations requires counties to dedicate a "majority" of MHSA CSS funding for FSPs. Counties also are allowed – subject to consultation with local mental health partners and community members – to use prevention and early intervention funds, with some limitations, to support children and youth who may need FSP services.

Full Service Partnership Programs

A unique quality of Full Service Partnerships (FSPs) is that the approach to treatment planning and service delivery emerges from a negotiation between the client and the provider. The question that launches the treatment planning process is often, "What do you need as a partner in your recovery journey?"

Figure 2: Mental Health Continuum



FSP programs under the MHSA are team-based and recovery-focused, typically based on intensive case management or assertive community treatment (ACT).[6] The approach to FSPs is not manualized or standardized. Each FSP participant is intended to receive services and supports that are tailored to their needs and integrated through the "whatever it takes" approach. Recognizing that FSP clients often have a long history of unmet mental health needs and considerable involvement with hospitals and the criminal justice system, access to care is available around the clock. A Personal Services Coordinator/Case Manager is required to respond to the client or family 24 hours a day, 7 days a week to provide after-hours support when necessary.[7]

[6] ACT is an evidence-based practice that uses a multidisciplinary team approach with assertive outreach in the community.
[7] California Code Reg. Tit.9 § 3620

Clients can be referred into an FSP from psychiatric hospitals, emergency departments, and other mental health programs, as well as outreach workers, homeless shelters, jails, and community-based organizations.

Each California county behavioral health department establishes eligibility criteria for participation in an FSP program and many FSPs are run by contracted providers which results in additional variation in program design and eligibility within a given county. Despite that variation, clients typically must meet the following criteria: be homeless or at risk of homelessness; involved or at risk of involvement with the criminal justice system; frequently hospitalized for mental health challenges or frequent users of emergency department services.[8]

Types of FSPs

FSPs are designed and tailored to address the needs of various age groups and subpopulations:

- Child FSPs: intensive in-home mental health service program for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.
- Transition Aged Youth (TAY) FSPs: comprehensive and higher-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.

[8] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201100384

- Adult FSPs: Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.
- Older adult FSPs: for adults 60 and older with histories of homelessness and/or incarceration, these FSP programs often use the Assertive Community Treatment (ACT) model.
- Forensic FSPs: These programs have a focus on justice-involved adults with serious mental health needs and co-occurring substance abuse disorders.

Evidence of Success

Earlier iterations of FSPs had demonstrated measures of success, such as fewer hospitalizations, increased housing stability, and less involvement with the criminal justice system. Since the passage of the MHSA in 2004, there have been several evaluations to determine statewide impact, along with numerous local efforts to quantify the success of FSPs. These evaluations show that FSPs can be highly effective at achieving the goals of lower criminal justice involvement, reductions in homelessness, fewer hospitalizations and emergency department visits, and cost savings.

Local Evaluations

- Cost savings: A 2018 report by RAND found that Los Angeles' FSP investment has resulted in $82 million in cost savings over five years.[9]
- Improved housing and less criminal justice involvement: San Francisco's FSP evaluation found a reduction in arrests and time in other restrictive settings along with improvements in the quality and stability of housing.[10]

[9] https://www.rand.org/pubs/research_briefs/RB10041.html
[10] https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/SFMHSA5YearReport-2010.pdf

- Improved access to services and less homelessness: San Diego County found that participation in an FSP was associated with improved access to care and better housing outcomes.[11]

Statewide Evaluations

- Fewer emergency department visits: One study found that FSPs were highly effective in reducing emergency department visits – compared to usual care, the odds of FSP clients visiting the emergency department were 54 percent less after 12 months of treatment and 68 percent less after 18 months.[12]
- Decline in emergency mental health services: In a study looking at children ages 11-18, researchers found that before FSP enrollment, participating children had high and increasing rates of mental health emergency services, and after enrollment, had rapid reductions in emergency services use compared to children who did not receive FSP services.[13]
- Less criminal justice involvement: An internal analysis conducted by the Commission draws upon data from FSP providers and criminal justice data from the California Department of Justice. That work found a strong association between FSP participation and reductions in arrests. Participants had a 47 percent reduction in arrests in the 12 months following participation in an FSP compared to 12 months before participation.

These and other evaluations indicate that FSP programs can and do reduce criminal justice involvement, emergency department and psychiatric inpatients stays, and improve housing stability.

[11] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/210805
[12] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201100384
[13] https://www.ingentaconnect.com/content/wk/mcar/2017/00000055/00000003/art00015

Guiding Questions

The history and initial evaluations of FSP programs suggests they represent opportunities to drive down the numbers of Californians who are unhoused, justice involved and facing hospitalization because of unmet mental health needs, yet California has seen increases in each of those challenges.

Cities and towns across the state are struggling to meet the needs of people living in encampments throughout the state. Research suggests the number of people who are homeless in 2022 increased by 22,500 from 2019 to reach 173,800.[14] While housing affordability is a primary driver of homelessness, individuals with mental health needs are particularly vulnerable and at risk. Current data on the numbers of the unhoused Californians with mental health needs are limited; however, research done prior to the pandemic found that rates can be as high as 75 percent for the chronically homeless, and between 30 and 50 percent for the population of unhoused.[15]

Similarly, the state faces an increase in the number of Californians who are determined by the courts to be incompetent to stand trial and committed to programs administered by the California Department of State Hospitals. The state is investing more than $1 billion in a multi-year plan to address the increased need for services through 2025-26. Research from the Department of State Hospitals indicates that individuals coming into the state hospital system are cycling through the local criminal justice system – with nearly half having 15 or more arrests prior to being sent to a state institution, with many of those failing to receive community mental health services in the six months prior to the latest charge that resulted in a state hospital commitment. The California Department of State Hospitals also reports that

[14] https://calmatters.org/housing/2022/10/california-homeless-crisis-latinos/
[15] https://siepr.stanford.edu/publications/policy-brief/homelessness-california-causes-and-policy-considerations#:~:text=The%20prevalence%20is%20particularly%20high,Culhane%201998%3B%20Poulin%20et%20al

some 71 percent of clients return following discharge from a state hospital with new felony charges and an Incompetent to Stand Trial designation by the courts.[16]

State officials suggest the increase in demand for state hospital beds is directly tied to the number of Californians with Schizophrenia Spectrum disorders who are not receiving community-based care and, as a result, are becoming involved with the criminal justice system.

Community hospitals also report high numbers of mental health clients cycling through hospital emergency departments, and confusion over the role of contracted FSP providers when clients land in emergency departments needing crises mental health services.

Finally, in its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing numbers of Californians with serious and persistent mental health needs that are going unmet.[17]

The Commission's initial review of data relating to FSP identifies three primary concerns:

1) The State faces data quality challenges that impede its capacity to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization.
2) Despite regulatory requirements, county behavioral health departments do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3) California has not established sufficient technical assistance and support to ensure that FSP programs are meeting to goals of reducing homelessness, hospitalizations

[16] https://www.dsh.ca.gov/About_Us/docs/IST_SolutionsBudgetOverview_08-01-22.pdf
[17] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

and justice involvement.

Despite the initial success of FSPs, significant numbers of Californians with mental health challenges lack stable housing, are involved in the criminal justice system, and are cycling through state and community hospitals. These concerns suggests that California's investment in FSPs is not meeting the current need and raises the following questions:

1) How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?
2) What lessons can be learned from exemplary programs to improve the efficacy of the overall FSP initiative?
3) Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs and intended outcomes?
4) What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?

These questions, along with the descriptive questions outlined in Welfare and Institutions Code 5845.8 are addressed below.

How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?

To address this question, the Commission explored existing state data systems that contain information on persons served by Full Service Partnerships. Unfortunately, the data in the state's primary FSP reporting system is inadequate to provide clear and reliable information on the effectiveness of individual FSPs and the broader FSP initiative.

The Department of Health Care Services maintains a Data Collection Reporting (DCR) tool that was designed to receive information on FSP programs across the state. The DCR was intended to gather information on FSP enrollments, key events in the life of participants, and quarterly updates on progress toward goals and services received. Preliminary review of data from the DCR indicates significant gaps in required reporting. For instance, the DCR is intended to gather demographic data on persons served. Demographic data are important to enable the tracking of disparities in access to care across racial, ethnic, age and gender subsets of California's population. A review of data from the 2020-21 fiscal year revealed more than a third of persons listed as receiving FSP services had no racial, ethnic or gender data linked to their FSP enrollment through the DCR.

The DCR also includes a reporting requirement for "Key Events," defined as any significant change related to housing, education, employment, emergency services, arrests, health issues, transfer to a new FSP provider, or disenrollment from the program. These events are reported through a Key Event Tracker, which is intended to provide a snapshot of changes in key quality of life areas that are tracked on a continuous basis throughout the course of participation in the FSP. There is no limit to the number of key events that can be submitted into the data system and monitored over the course of FSP enrollment.

Recognizing that Key Event data can reflect incidents of arrests, housing instability, hospitalizations, and changes in FSP enrollment, these data are of high value in demonstrating outcomes associated with FSP involvement. To meet the goals of FSP involvement, key events should trend toward stability in care, housing, and avoidance of criminal justice involvement and hospital use. Currently key event data are unavailable for a significant subset of FSP clients. Given the considerable risks that FSP clients face for criminal justice involvement, housing instability and hospitalization, the Commission would

anticipate robust data on key events for enrollees. It is unclear if key event data are not being submitted by providers, if the data are not finding their way into the Key Event Tracker, or if there a high percentage of FSP enrollees who fail to experience "key events," which would seem unlikely.

Through the DCR the state has the potential to track relevant information about key events of a consumer as they move through an FSP; however, the DCR does not track other critical information such as services provided and progress toward goals. This information is more likely to be captured in provider/county electronic health records, and there is currently no data reporting mechanism by which that information is reported to the state.

In the absence of more complete data sets on FSP participants, the Commission has explored opportunities to link FSP enrollment data with other data sets on justice involvement, hospitalization, employment, and housing status. As reference above, the Commission pursued an exploratory link between data held in the DCR with data gathered by the California Department of Justice (DOJ). Those data were reflected justice involvement prior to 2018. We are currently working to receive updated data from the DOJ that can be linked to current FSP enrollment data.

Similarly, the Commission is working to identify potential datasets that can be linked to DCR client data to explore hospital use, employment, homelessness and housing status.

To improve the ability to monitor the outcomes and impacts of FSPs on key priorities, the Commission is exploring the strengths and limitations of the existing data systems and strategies to improve access to existing data, pathways to improved state-level reporting and the need to streamline reporting requirements. It is unclear if existing data reporting requirements are cost-effective and how they could be modified for improve cost-

effectiveness. To pursue these questions and develop potential recommendations, the Commission will work with the Department of Health Care Services, mental health clients supported by FSPs, county behavioral health leaders, FSP providers, and other subject matter experts.

What lessons can be learned from exemplary programs to improve the efficacy of California's overall FSP initiative?

In 2019 the Commission partnered with ten local behavioral health departments and a non-profit consultant to explore strategies to strengthen emphasis on outcomes through the design and delivery of FSP services. This project, the Multi-County FSP Innovation built upon a project launched by the Los Angeles County Department of Mental Health with support from Third Sector, a non-profit technical assistance provider. Following Los Angeles County's initial work, the Commission provided financial support to extend participation to nine additional counties. The project was designed to strengthen how counties contract for FSP services with an emphasis on creating incentives for FSP providers to focus on outcomes. In addition to Los Angeles, Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, Ventura, Stanislaus, Napa, and Lake counties participated in the Multi-County FSP Innovation Project, in partnership with Third Sector. The project was designed with the following goals:

- Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.
- Increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.
- Improve how counties define, and pursue priority outcomes across FSP programs.
- Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.

- Develop new and/or strengthen existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

To allow for flexibility, FSP programming can vary greatly from county to county, with different operational definitions and data processes; however, this diversity of approaches presents challenges in understanding and telling a statewide impact story. The Multi-County FSP Innovation Project is intended to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties are leveraging the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.[18]

Participating counties worked together to identify standardized measures for tracking what services individuals receive and how successful those services are. Guided by more than 200 interviews with FSP consumers, family members, and peers, 50 provider focus groups, and recommendations around evidence-based practices, the counties selected and defined five measures to compare across counties for adult FSP participants:

- Frequency and location of services
- Increased stable housing, including stable, temporary, and unstable housing arrangements
- Reduced justice involvement; including incarcerations and arrests
- Reduced utilization of psychiatric services; including reduced psychiatric and crisis stabilization unit (CSU) admissions
- Increased social connectedness

[18] https://tscp.wpenginepowered.com/wp-content/uploads/2022/03/Multi-County-FSP_Year-2-Summary-Report-2-10-FINAL-1.pdf

While some of these outcome measures were historically collected, none were tracked with consistent definitions or metrics across counties. These new, standardized measures should allow participating counties to share and discuss their data collaboratively, identify best practices, and engage in continuous improvement activities collectively. In addition, these counties now collect and track social connectedness data – a recommendation elevated by service recipients – as a key outcome for individuals with serious mental illness.

As part of the Multi-County Full Service Partnership Innovation Project, counties came up with a set of recommendations to the Department of Health Care Services (DHCS) to improve the DCR system. These recommendations were drafted into a memorandum and submitted to DHCS, acknowledging the department's Comprehensive Behavioral Health Data Systems Project to modernize and streamline data reporting across California's multiple behavioral health data systems, including the DCR. The Commission endorses these recommendations which include concrete feedback on improving communication support, technical system enhancements, and pre-procurement process suggestions.

The Multi-County Full Service Partnership Innovation Project is currently in its evaluation phase and involved a limited subset of county behavioral health departments. Consistent with the comments above, the Commission will continue its work with the Multi-County Innovation project, explore opportunities following the evaluation to engage additional counties and partner with the Department of Health Care Services to improve the utility of existing data reporting requirements and data systems.

Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs?

In 2021, the MHSA generated an estimated $2.8 billion in funding to support community mental health services. Of those funds, $2.3 billion were distributed to

county behavioral health departments, which resulted in the following allocations:

- Community Services and Supports (CSS): $1.6 billion
- Prevention and Early Intervention (PEI): $423 million
- Innovation: $99 million

State regulations require "a majority" of CSS funds to support FSP programs. However, in 2010, likely in response to fiscal uncertainties the state was facing at the time, the former Department of Mental Health issued an Information Notice clarifying that for the 2011-12 fiscal year only, the state would calculate the minimum FSP investment to reflect all FSP expenditures, including any federal funding used to support FSP programs. The Information Notice changed the rules for county FSP spending from requiring counties to meet their "majority" expenditure requirement with MHSA revenues, with federal and other funds being in addition to the MHSA investment, to a new formula that would lower MHSA and thus overall expenditure requirements for FSPs. County behavioral health officials state that despite Information Notice 10-21 communicating that this change in fiscal rules applied only for the 2011-12 fiscal year, in the absence of subsequent information, the counties have continued to operate under the temporary direction.

The Mental Health Services Act was passed with clear and compelling goals to reduce justice involvement, homelessness and support community-based care, which is often interpreted as meaning also reducing reliance on hospitalization. The subsequent regulatory requirement to dedicate the "majority" of Community Services and Support funding for FSPs signals the opportunity that FSPs represent to avoid these negative outcomes. Yet uncertainly on the state's fiscal rules has hampered opportunities to ensure an adequate investment in FSPs across California's 59 local behavioral health agencies.

As part of its work under the terms of SB 465, the Commission will work with the Department of Health Care Services and county behavioral health leaders to clarify the fiscal requirements relating to FSPs and strengthen utilization of existing resources to support improved FSP outcomes.

What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?

As depicted in Figure 2 above, FSPs exist within a continuum of services and are at the higher end of treatment services. While existing state databases do not allow a clear understanding of who is presently served by FSP providers, discussions with state and county behavioral health leaders indicate that FSPs are best suited to support persons with schizophrenia and related disorders that involve psychosis. As such, the Commission is working to explore opportunities to best engage individuals at the initial stage of psychosis and to prevent the escalation of needs that would result in new demands on FSP programs. In other words, the State of California needs to build out a robust FSP service delivery system that is responsive to the needs of people with serious and persistent mental health care needs, and the state also must work to reduce the escalation of mental health needs and the demand for FSP services.

Research on early psychosis intervention indicates that there are clinically beneficial and cost-effective approaches to care delivery that can prevent the escalation of needs.[19] The Governor and Legislature have supported several initiatives to increase upstream

[19] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-015-0650-3

interventions that can lower demand for high-cost FSP services, particularly the expansion of access to early psychosis interventions.

As the Commission's work on Full Service Partnerships progresses, we want to explore the impact that expanded access to early psychosis services can have as an FSP prevention strategy.

Immediate Opportunities and Next Steps

Developing a Strategic Reporting and Capacity Building Plan

Given the requirements of the Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021) and the learning from the four key questions established in this initial report, there is significant groundwork to cover before the next report is due in November 2024.

The Commission's strategic reporting and capacity building plan for FSPs will incorporate clear and concise goals and objectives for data collection, monitoring, and reporting. It will incorporate a plan and process for community engagement and outline a process for capacity building, program improvement, and community feedback.

The plan also will reflect principles of diversity, equity, and inclusion, to ensure that the state's investment in Full Service Partnerships supports efforts to reduce disparities, particularly as they relate to criminal justice involvement, homelessness, and hospitalization.

As mentioned above, the process for developing a strategic data reporting and capacity building plan will incorporate the following:

1. Formation of an Advisory Group. The Commission will convene a group of subject matter experts to inform the work moving forward, including FSP

providers, state and local agencies representatives, consumers, family members, and others. The Advisory Group will be tasked with informing all aspects of the Commission's work on FSPs.

2. Identify Opportunities for Capacity Building. As the Commission has learned through the Multi-County FSP Innovation Project, there is diversity in FSP programs in terms of eligibility criteria, services provided, step-down criteria, other program elements and measures of success. The project also has revealed opportunities to engage county behavioral health leaders, FSP providers and others to support capacity building and technical assistance to improve the design and delivery of FSP services and supports. The Commission is exploring opportunities to build off of the Multi-County FSP Innovation Project, involve more counties and improve access to technical assistance and support for all counties.

3. Conducta landscape analysis to understand FSPs within the continuum of prevention, early intervention, and treatment. With the passage of the CARE Act, greater attention to individuals who are deemed Incompetent to Stand Trial, and efforts across California to enhance early psychosis programs, there is a tremendous opportunity to critically examine where FSPs fit into California's larger continuum of care. For example, investing in upstream prevention and early intervention approaches should, over time, reduce the number of individuals who need FSP services. In other words, if the system of care can identify, treat, and stabilize an individual at the point of their first psychotic break, evidence suggests that their trajectory changes and they are less likely to become homeless, develop substance use disorders, and become involved in the criminal justice system. The Commission will work with and support related efforts underway at the Department of Health Care Services.

4. Data quality improvement efforts. As discussed, there are numerous data issues with the DCR related to accuracy, completeness, and quality. For example, without complete data on race/ethnicity, it is difficult to disaggregate results to explore potential disparities in outcomes by race/ethnicity. The DCR also lacks service/treatment information making it impossible to map specific services to positive outcomes. The Commission will explore opportunities to collaborate with DHCS and county partners (e.g. the Multi-County Innovation project on FSPs) on existing efforts to improve these data systems so that they accurately tell the FSP story and help document success and challenges across the state.
5. Data linkage and population-based analyses. The Commission will explore opportunities with the Department of Health Care Services to link individual-level data from the DCR with other state-based datasets, such as data from the California Department of Health Care Access and Information and the DOJ, to better understand population-level outcomes associated with FSP services.
6. Provide recommendations for investment strategy for FSPs. Given the confusion over expenditure rules and uncertainty over whether individuals who meet the criteria for FSP services are getting enrolled and served, the Commission is exploring opportunities to analyze current FSP expenditures, develop an estimate of unmet need in the state, and potential recommendations for reforming expenditure rules, establishing expectations for expanding FSP treatment capacity, and related strategies.

Appendices

Data Sources for FSP Analysis

The State of California has four primary data sources available to understand the operations of Full Service Partnerships (FSPs) and the outcomes they achieve for mental health clients and the communities where they live. The Department of Health Care Services maintains two of those data systems: the Data Collection and Reporting (DCR) system, which was designed specifically to receive information on clients involved with FSP, and; the Client Information System (CSI), which has data on all mental health clients served by county mental health departments. Additional data systems include those maintained by the California Department of Health Care Access and Information (HCAI), which includes data on hospitalizations and discharges, and data held by the California Department of Justice relating to criminal justice involvement.

To support this initial effort and future work, the Commission will primarily rely on these data systems and access additional data, or data collection methods, as needed.

Under existing state regulations, each county behavioral health department is required to submit to the state detailed data on clients served through Full Service Partnerships. Those requirements are outlined in Title 9 of the California Code of Regulations. At the time an individual enters into a FSP, the county is required to collect the following information and submit it to the Department of Health Care Services (DHCS) within 90 days:

- Residential status, including hospitalization or incarceration
- Educational status
- Employment status
- Legal issues/designation

- Sources of financial support
- Health status
- Substance abuse issues
- Assessment of daily living functions, when appropriate
- Emergency interventions

Additionally, at any time during the course of participation in an FSP, counties also are required to report any emergency interventions, or changes in living situation, educational or employment status and criminal justice involvement. The reports are known as Key Event reports. Counties also are required to provide quarterly assessments for each FSP participant that provide data on the following:

- Educational status
- Sources of financial support
- Legal issues/designation
- Health status
- Substance abuse issues

As with the initial assessment data, Key Event data and quarterly assessment date are required to be submitted to the DHCS within 90 days of collection.

In addition to the DCR system, which holds data only on FSP clients, DHCS maintains the CSI data system, through which counties are required to report information to the state on all persons receiving mental health services from a county. Those receiving services through Medi-Cal and those who are not enrolled in Medi-Cal are required to report into the state's CSI

data system. Counties are required to report on client demographics and descriptions of the services provided within 90 days of providing services (CCR Title 9, 3530.10, Information Notice 19-051).

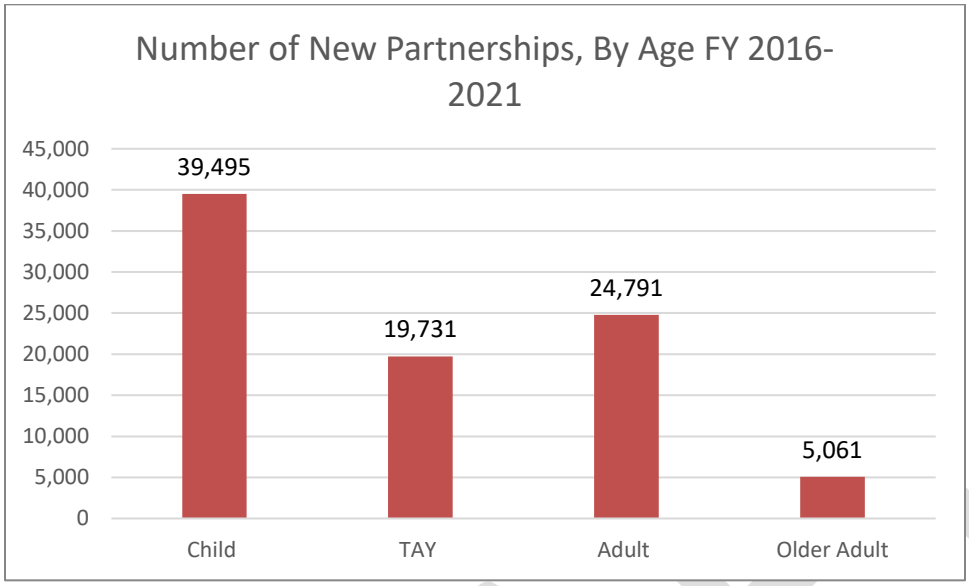
The Commission receives data regularly from the DHCS to support existing efforts to monitor FSP programs. These data sources include: FSP DCR database and the MHSA CSI. Additional data use agreements with the HCAI provide the Commission with patient discharge data (PDD) for hospitalizations.

Initial Data Analysis

Partnerships by Age

Figure 2 shows the number of new partnerships (e.g. clients) who enrolled in an FSP over the last five years (between FY 2016-2021), by age group. Child FSPs are an important service, with 44% of all new partners falling into the 0-15 age group. The percentage of clients by age group has remained stable over the last five years, with children constituting approximately 45% of new enrollments; transition age youth were 22%; adults were 28%; and older adults were 6%.

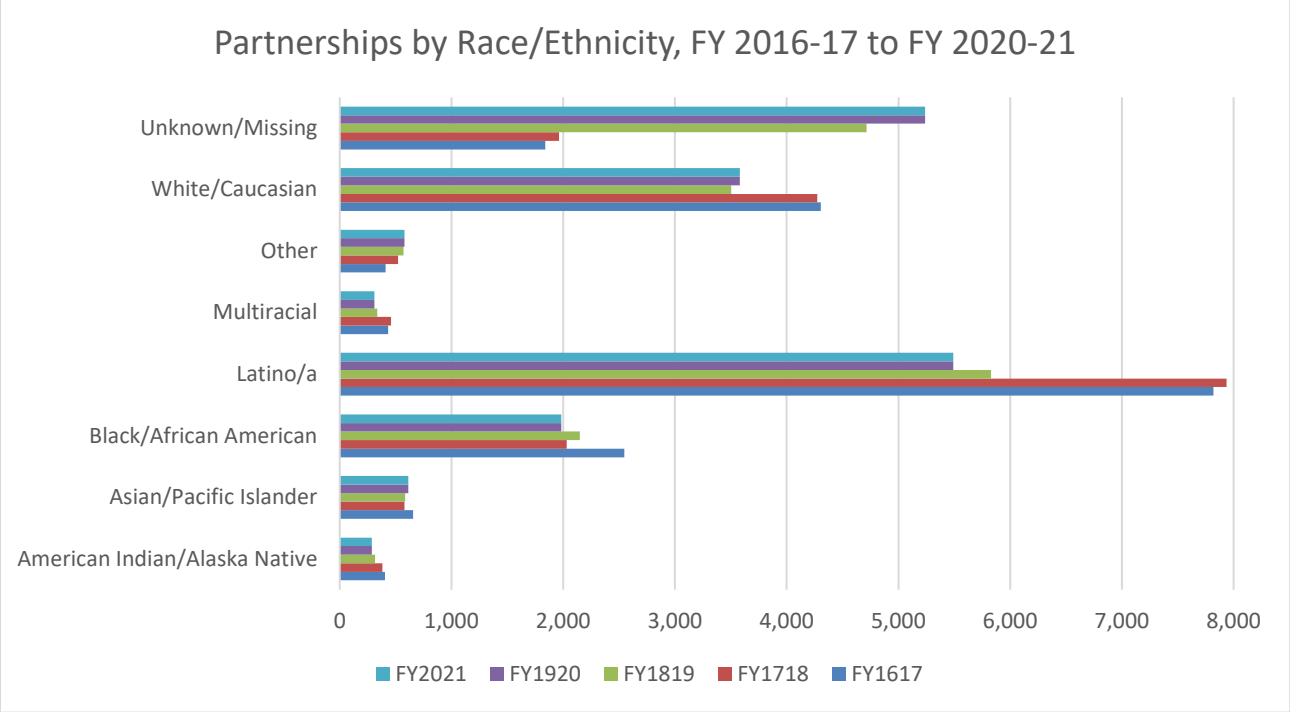
Figure 3: Number of New Partnerships, By Age, FY 2016-2021



Partnerships by Race/Ethnicity

Comparing trends by year for partners served by race/ethnicity is challenging because the number of partners with no race/ethnicity reported in the DCR has increased.

Figure 4: Number and Percentage of Partners by Race/Ethnicity, FY 2016-17 to 2020-21



Partnerships by Gender

Comparing trends by year for partners served by gender is also challenging because the number of partners with no gender identified increased between FY 2016-17 and FY 2020-21. In FY 2016-17, 53% of those served identified as male; 43% as female; 5% as Other; and less than 1% were Unknown. In contrast, in FY 2020-21, gender was designated Unknown for 27% of partners. The challenges of the COVID pandemic may have impacted data quality.

Discharges from FSPs

One of the triggers for a Key Event Tracker (KET) is a discharge of a client from the FSP. There are multiple reasons why a partnership might be discontinued, including:

- Target population criteria not met
- Partner decided to discontinue FSP participation
- Partner moved to another county/service area
- After repeated attempts to contact partner, they cannot be located

- Community services/program interrupted (e.g. partner moves to a higher level of care, will be serving a jail sentence, placed in juvenile hall, serving prison)
- Partner has successfully met their goals such that discontinuation of FSP services is appropriate

Of the 215,404 partners in the DCR system, 164,902 had a KET with a discharge reason (76.6%). Over the last five years, there were 58,482 discharges. Table 1 summarizes the reasons for discharge.

Table 1: Reasons for Discharge from FSP, 2016-2020

Reason for Discharge	**Percentage**
Met Goals	41%
Partner discontinued FSP partnerships	19%
Partner could not be located	18%
Partner moved to a different service area or county	10%
Service interruption (e.g. jail, prison, juvenile hall, residential treatment	7%
Target population criteria not met	5%
TOTAL	**100%**

An initial analysis of inpatient hospitalizations was conducted. Inpatient admissions were identified between one year before each FSP began, during the FSP, and for one year after the FSP ended. Table 1 shows that inpatient admissions one year after FSPs between FY 14/15 and FY18/19 were less than half the number of admissions in the year before each FSP began (46 per 100 FSPs before and 20 after). For each year examined, inpatient admissions reduced significantly during the FSPs and even more after the FSP as compared to the year before.

Table 2: Psychiatric Inpatient Admissions Before, During, and After FSP, FY 2015-FY 2018

		Psych Inpatient Admissions			Annualized Admissions per 100 FSP Years			Change After/Before		
FY	Nbr. FSPs*	Before	During	After	Before	During	After	Ratio	t-value	Prob t
FY14/15	12,674	7,098	5,580	2,972	56	38	23	0.42	-25.0	<.0001
FY15/16	13,149	6,996	4,727	3,122	53	36	24	0.45	-21.8	<.0001
FY16/17	15,640	6,742	3,957	2,748	43	32	18	0.41	-23.1	<.0001
FY17/18	13,541	5,029	2,463	2,318	37	28	17	0.46	-19.9	<.0001
FY18/19	5,048	1,720	542	841	34	27	17	0.49	-9.2	<.0001
Total	60,052	27,585	17,269	12,001	46	34	20	0.44	-45.6	<.0001

AGENDA ITEM 7

Action

January 25, 2023 Commission Meeting

Santa Barbara County Innovation Project

Summary: The Commission will consider the approval of Santa Barbara County's request to expend up to $7,552,606 in MHSA Innovation funds over four and a half years for the following project:

Housing Assistance and Retention Team (HART)

Santa Barbara is making progress towards reducing homelessness among those living with mental health conditions with the addition of 61 permanent supportive housing units added over the past two years and another 76 units becoming available in the next four years through the use of Mental Health Service Act, Homekey and No Place Like Home (NPLH) funding.

Despite these efforts, the County identified data during Fiscal Year 2020-21, revealing that 26% of individuals living with a mental health condition and housed through the County's Coordinated Entry System returned to homelessness within six months. The County has also been notified that some of the individuals living in MHSA and NPLH-funded housing are either being evicted or facing charges of housing infractions, even though the County currently provides twenty hours per week of onsite supportive services.

In response, the County is proposing to implement a three-prong approach to increase housing retention and increase access to mental health services within their existing permanent supportive housing program by launching the HART Project which is intended to:

- Assist clients as they transition into independent living by adding an intensive, peer-driven supportive component within existing permanent housing programs,
- Educate and train housing authority and other property management staff on how to best serve this vulnerable population, and
- Create data collection methods that drive decision making and identify emerging trends.

HART will consist of on-site staff, including a housing program manager, SSI/SSDI Outreach, Access and Recovery (SOAR) trained case workers, a peer team supervisor, and peer support specialists. The services team will be peer-led with a goal of being 100% peer staffed.

<u>Community Planning</u>

During the MHSA 2020-2023 three-year community planning process, Santa Barbara County's community partners ranked persons experiencing homelessness as the number one

population not being adequately served by current MHSA programs. In addition, addressing homelessness and adequate housing supports were needs discussed by community partners at all fourteen stakeholder events and in written comments provided during the MHSA 2022-2023 annual update process.

Santa Barbara County's community planning process included the following:

- A 30-day public comment period: November 18, 2022 through December 20, 2022;
- A local Mental Health Board Hearing: December 22, 2022; and,
- The Board of Supervisor's Approval: January 24, 2023.

A final plan, incorporating community partner input as well as technical assistance provided by Commission staff, was submitted on December 22, 2022.

Commission Level

This project was initially shared with Community Partners on November 22, 2022, and the final version was again shared on December 22, 2022. Additionally, this project was shared with the Commission's Client and Family Leadership and Cultural and Linguistic Competence Committees.

> *A comment was received from a former member of the Client Family Leadership Committee (representing family members) on December 20, 2022 and January 3, 2023, summarizing the project and providing their support for this project.*

Enclosures (3): (1) Commission Community Engagement Process; (2) Biography for Natalia Rossi, JD., MHSA Manager, Santa Barbara County Department of Behavioral Wellness - Santa Barbara County Presenter; (3) Staff Analysis: Housing Assistance and Retention Team Program

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

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following:

Santa-Barbara-County_-INN-Plan_HART_12212022_Final.pdf (ca.gov)

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

Name:	**Housing Assistance and Retention Team Program**
Amount:	**Up to $7,552,606 in MHSA Innovation funds**
Project Length:	**Four and a half (4.5) years**

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

Natalia Rossi, Mental Health Services Act Manager

Santa Barbara County Department of Behavioral Wellness

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Natalia Rossi is a California State licensed attorney and has worked for the Santa Barbara County Department of Behavioral Wellness for almost six years. She assumed the role of MHSA Manager for the Department nine months ago, and prior to that worked as the Department Training Coordinator, SCRP Coordinator, and Grants Coordinator for all Housing and Homeless Services Grants. In addition to her Juris Doctorate, Natalia has a Master's in English.

Natalia remains passionate about fighting for mental health service parity to those most in need in her community, particularly mental health consumers and those that are unhoused.

STAFF ANALYSIS – SANTA BARBARA COUNTY

Innovation (INN) Project Name:	**Housing Assistance and Retention Team Program**
Total INN Funding Requested:	**$7,552,606**
Duration of INN Project:	**4.5 Years**
MHSOAC consideration of INN Project:	**January 25, 2023**

Review History:

Approved by the County Board of Supervisors:	(Pending) January 24, 2023
Mental Health Board Hearing:	December 21, 2022
Public Comment Period:	Nov. 18, 2022-Dec. 20, 2022
County submitted INN Project:	December 22, 2022
Date Project Shared with Stakeholders:	Nov. 22, 2022 and Dec. 22, 2022

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, as well as increasing access to mental health services, including but not limited to services provided through permanent supportive housing.

This Proposed Project meets INN criteria by supporting participation in a housing program designed to stabilize a person's living situation while also providing onsite supportive services.

Project Introduction:

The County is proposing to use a three-prong approach to increase housing retention and increase access to mental health services within their existing permanent supportive housing program by:

- Assisting clients as they transition into independent living, by adding an intensive, peer-driven supportive component within the current permanent housing programs,
- Educating and training Housing Authority and other property management staff on how to best serve this vulnerable population, and

- Creating data collection methods to drive decision making and identify emerging trends.

What is the Problem:

Santa Barbara County community partners have identified the needs of persons experiencing homelessness as a top priority.

To decrease homelessness among those living with mental health conditions, the County has utilized Mental Health Service Act (MHSA), Homekey and No Place Like Home (NPLH) funding to add 61 permanent supportive housing units over the past two years. Santa Barbara was recently awarded additional funding for 76 more units that will begin to house individuals in the next 3-4 years.

While Santa Barbara is making progress towards reducing homelessness, data identified during Fiscal Year 2020-21 revealed that 26% of individuals living with a mental health condition and housed through the County's Coordinated Entry System returned to homelessness within six months of being housed. The 2022 "point in time" count identified 1,962 unsheltered individuals in Santa Barbara County.

In addition, the County has been notified that some of the individuals living in MHSA and NPLH funded housing are either being evicted or are facing housing infraction charges, even though the County currently provides twenty hours per week of onsite- supportive services at those sites.

The County interviewed tenants, clients, and onsite staff and discovered there were specific barriers to housing retention, including county, landlord, and tenant-based issues:

- Lack of current supportive services for tenants, many of whom have not successfully lived independently for years, resulting in tenants:
    - Being evicted from permanent supportive housing, often because they lack the necessary supports when first entering housing after periods of being unhoused,
    - Lacking basic supplies, food, and transportation especially when they are transitioning from homeless to housing,
    - Not being enrolled in the social benefits programs to which they are entitled.
- Property management staff who are not properly trained on how to best support this unique population. Tenants report not feeling comfortable working with property management staff to resolve issues before they become infractions or result in evictions.
- Lack of data to support or explain why people lose housing, making it difficult to prevent these hardships in the future.

How this Innovation project addresses this problem:

The Housing Assistance and Retention Team (HART) will test a three-pronged approach to the barriers identified above to increase housing retention and increase access to mental health services within their existing permanent supportive housing utilizing a collaborative, wrap around approach utilizing Housing First principles.

The first prong will focus on assisting clients as they transition into independent living, by adding an intensive, peer-driven supportive component within the current permanent housing programs. **This will be the first peer-driven, on-site housing support program in the County**. Highlights of the peer-driven support component will include case workers and peer support specialists working collaboratively to:

- Create an eight-week independent living skills curriculum program for clients as they transition into permanent supportive housing utilizing evidence-based practices.
- Establish a "warm line" to provide twenty-four hour a day peer support.
- Provide daily in-person support to help residents maintain and strengthen their independent living skills and connect them to mental health and substance use services.
- Provide transportation support for tenants and utilize available flex funding to ensure tenants have necessary items needed upon move-in.

The second prong is focused on educating and training Housing Authority and other property management staff on how to best serve this vulnerable population. To address the lack of training among housing staff, HART staff will develop and implement a training program with fidelity to the Housing First model.

Lastly, the HART Team will hire an epidemiologist who will develop data collection instruments and reporting mechanisms to assess program success and identify challenges and housing trends. Please see below for more details included in the evaluation section.

The HART team will consist of a Housing Program Manager, SSI/SSDI Outreach, Access and Recovery (SOAR) trained case workers, a Peer Team Supervisor, and peer support specialists. The services team will be peer-led with a goal of being 100% peer staffed. The HART team will receive intensive training including Trauma-Informed Care; Seeking Safety; Mental Health First Aid; CPR/AED; Admission of NARCAN; SOAR; Critical Time Intervention Training; Motivational Interviewing; and Voluntary Moving-On Strategies.

The Community Program Planning Process

Local Level

During the MHSA 2020-2023 Three Year Plan community planning process, Santa Barbara County's community partners ranked persons experiencing homelessness as the number one population not being adequately served by current MHSA programs. In addition, addressing homelessness and adequate housing supports were needs discussed by community partners at all fourteen stakeholder events and in written comments provided during the MHSA 2022-2023 Annual Update process.

In February 2022 Santa Barbara released a housing survey that was key in developing this project. **Following the survey, staff held three focus groups at three housing sites to further understand the needs of residents. Staff then held work groups to further develop and refine the project. Project refinement also included incorporating lessons learned**

from local programs and the review of several housing support programs in other counties.

Santa Barbara County's community planning process included the following:

- 30-day public comment period: November 18, 2022 through December 20, 2022
- Local Mental Health Board Hearing: December 22, 2022
- Board of Supervisor Approval: Scheduled for January 24, 2023

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 22, 2022.

Commission Level

This project was initially shared with Community Partners on November 22, 2022, and the final version was again shared on December 22, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

> *A comment was received from a former member of the Client Family Leadership Committee (representing family members) on December 20, 2022 and January 3, 2023, summarizing the project and providing their support for this project.*

Learning Objectives and Evaluation (pgs 13-16 of project):

The County indicates this project will serve approximately 60 individuals per year who are experiencing homelessness or are at risk of homelessness. Participants will not have to be actively engaged in services with the County to receive services from the HART team.

The County has set forth specific learning questions for this project and will hire an epidemiologist to work with their research and development team to develop data collection instruments and reporting mechanisms to assess program success and identify challenges and housing trends. Specifically, the epidemiologist will develop methods to track all evictions and tenants leaving housing, including the reasons for leaving housing. The epidemiologist will also track increases or decreases in access to behavioral health services.

Project Learning Questions include:

1. Does an intensive eight-week independent living skills course increase our residents' ability to retain housing for longer periods of time?
2. What measures help track reduction in evictions: changes in behavior, interventions, linkages and referrals made, independent living skills classes?
3. Are residents able to secure social service benefits in a timely manner, increase their income and employment opportunities, and have ready access to community supports with the addition of peer supported full-time, on-site housing retention staff?
4. Do residents report a positive increase in their physical and mental health as a result of wraparound services during their first two to three months of residency?

5. Do residents report that the eight-week skill building program has increased their confidence to live independently?
6. Do residents report improved relationships with property management staff?
7. How does the impact of comprehensive data collection affect our ability to identify trends, track infractions and evictions, and accurately represent program goals and outcomes?

The County hopes to learn if project outcomes reflect the following:

Goal 1: Increase housing retention for MHSA, Homekey and NPLH tenants
Goal 2: Increase tenants' ability to secure social service benefits and income
Goal 3: Increase positive resident physical and mental health outcomes
Goal 4: Implement independent living eight-week skill building curriculum course for new residents
Goal 5: Implement regular training for property management staff
Goal 6: Develop systems to connect HMIS and Clinical data sources for a robust, comprehensive collection and reporting process.

The Budget: *(see pgs 29-31)*

4.5 Year Budget	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	**TOTAL**
Personnel	$ 157,979	$ 315,958	$ 322,277	$ 328,723	$ 335,297	$ 1,460,234
Operating Costs	$ 19,500	$ 14,500	$ 14,500	$ 15,500	$ 14,500	$ 78,500
Evaluation*	$ -	$ -	$ -	$ -	$ -	$ -
Consultant Costs (CBO)	$ 507,942	$ 1,220,386	$ 1,235,474	$ 1,259,004	$ 1,279,984	$ 5,502,790
Indirect Costs	$ 55,293	$ 110,585	$ 112,797	$ 115,053	$ 117,354	$ 511,082
Total	$ 740,714	$ 1,661,429	$ 1,685,048	$ 1,718,280	$ 1,747,135	$ 7,552,606
Funding Source	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	**TOTAL**
Innovation Funds	$ 740,714	$ 1,661,430	$ 1,685,048	$ 1,718,279	$ 1,747,135	$ 7,552,606
Total	$ 740,714	$ 1,661,430	$ 1,685,048	$ 1,718,279	$ 1,747,135	$ 7,552,606

Santa Barbara County is seeking authorization to use up to **$7,552,606** in innovation funding over a four-and-a-half-year period. The budget includes costs for direct administrative staff and the cost to partner with a community-based organization (CBO).

- Personnel costs total **$1,460,234** (19% of the total project) and will cover costs and benefits for the following staff (including staff to complete the evaluation*):
  - 1.0 FTE Housing Project Manager (lived experience preferred)
  - 1.0 FTE Epidemiologist to complete evaluation*.
- Administrative operating costs consist of:
  - Direct costs total **$78,500** (1% of total project) to cover costs associated with technology, client and staff training and property management outreach.
- Contractor costs total **$5,502,790** (72% of total project) and will cover the on-site direct services provided by staff including peer support workers and include:
  - Personnel costs

        - First Year – Pilot
            - 4.0 FTE Case Workers ($25/hour)
            - 5.0 FTE Peer Support Assistants ($22/hour)
            - 2.0 FTE Peer Supervisor ($30/hour)
        - Second and following years
            - 6.0 FTE Case Workers ($25/hour)
            - 6.0 FTE Peer Support Assistants ($22/hour)
            - 2.0 FTE Peer Supervisor ($30/hour)
    - Operating costs total **$515,000** and consist of client training, education and housing fund, travel, and technology.

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

AGENDA ITEM 8
Action

January 25, 2023 Commission Meeting

Alameda County Innovation Projects

Summary: The Commission will consider the approval of Alameda County's request to fund the following two innovation projects:

1. **Peer-Led Continuum for Forensic and Reentry Services – $8,692,893 in MHSA Innovation funds over five years.**
2. **Alternatives to Confinement – $13,432,651 in MHSA Innovation funds over five years.**

The County is proposing to test two projects targeted to address the same challenge of reducing criminal justice involvement for individuals living with mental health challenges.

The first project, Peer-Led Continuum – Forensic and Reentry Services, will include four programs led by certified forensic peer specialists with lived experience and trained family members with the overarching goal of reducing incarceration and increasing mental health services participation and engagement.

The second project, Alternatives to Confinement, will utilize clinical staff and requires law enforcement participation to divert individuals for mental health assessments in lieu of arrest by utilizing a Forensic Crisis Residential Treatment Center, an Arrest/Diversion Triage Center along with a program to assist in reducing probation and parole violations.

Both projects are part of the County's larger effort to address the high rates of criminal justice involvement for those living with mental health challenges. The services offered in both projects are designed to be voluntary in nature.

In September 2020, The County's Mental Health Task Force published a report based on stakeholder recommendations with emphasis on supporting reentry for individuals. Alameda's Behavioral Health also embarked upon research to develop a Forensic Mental Health and Reentry Plan, published shortly thereafter in October 2020. The Forensic Mental Health and Reentry Plan incorporated recommendations informed by the Mental Health Task Force along with evidence-based practices that aligned with the County's strategic goals.

After the release of these reports, which were published separately, by the County's Mental Health Task Force as well as the Forensic Mental Health and Reentry Plan, the County then contracted with the Indigo Project (Contractor) to engage the community in identifying components of these two reports that may warrant continued research and development.

Workshops were held where community partners and stakeholders provided ideas on how to best serve this population, including families of individuals living with mental health challenges who have experienced previous interactions with the criminal justice system. Some of the partners and stakeholders involved in these workshops included consumer representatives, individuals and families from NAMI, behavioral health providers, members of the County's African American subcommittee, and an MHSA stakeholder group. Discussions among community partners and stakeholders continued, resulting in the development of this project.

Alameda County's community planning process included the following:

- A 30-day public comment period: April 1, 2022 through April 30, 2022;
- A local Mental Health Board Hearing: May 16, 2022; and,
- The Board of Supervisor's Approval: June 13, 2022

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 5, 2022.

Commission Level

This project was initially shared with Community Partners on August 26, 2022, and the final version was again shared on December 5, 2022. Additionally, this project was shared with the Commission's Client and Family Leadership and Cultural and Linguistic Competence Committees.

> A comment was received on August 26, 2022, during the initial sharing of this project and offered support for this project and had specific questions for the County. Specifically, the individual requested to know if the services provided by this project would be available for City of Berkeley residents. The comment was forwarded to Alameda Behavioral Staff who then responded to Commission staff indicating that they would follow up with this individual directly. Commission staff emailed County on December 19, 2022, to follow up and County responded that they did reach out to this individual to discuss his questions.
>
> Another comment was received from a member of the Client Family Leadership Committee (representing family members) on December 18, 2022, summarizing the project and providing their support for this project.

Enclosures (4): (1) Commission Community Engagement Process; (2) Biography for Roberta Chambers, PsyD., Consultant, The Indigo Project - Alameda County Presenter; (3) Staff

Analysis: “Peer-Led Continuum for Forensic Reentry Services”; (4) Staff Analysis: “Alternatives to Confinement”

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

Additional Materials (1): A link to the County’s Innovation Plan is available on the Commission website at the following:

Link to Peer-Led Continuum for Forensic and Reentry Services Project Plan:
https://mhsoac.ca.gov/wp-content/uploads/Alameda_INN-Project_Peer-led-Continuum-for-Forensic-and-Reentry-Services_12.14.2022_Final.pdf

Link to Alternatives to Confinement Project Plan:
https://mhsoac.ca.gov/wp-content/uploads/Alameda-County_INN-Project-Plan_Alternatives-to-Confinement_Final_12.14.2022.pdf

Proposed Motions: The Commission approves Alameda County’s Innovation Projects, as follows:

1. **Name:** **Peer-Led Continuum for Forensic and Reentry Services**
   Amount: **Up to $8,692,893 in MHSA Innovation funds**
   Project Length: **Five (5) years**

2. **Name:** **Alternatives to Confinement**
   Amount: **Up to $13,432,651 in MHSA Innovation funds**
   Project Length: **Five (5) years**

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

Biography for Alameda County Presenter
Dr. Roberta Chambers, PsyD

Peer-Led Continuum Forensic and Reentry Services
and
Alternatives to Confinement
Innovation Projects

Dr. Roberta Chambers, PsyD, has been working in public behavioral health system for over twenty years. Since 2011, Dr. Chambers has worked as a consultant to the public mental health systems across California and in Nevada and owns a consulting firm, Indigo Project. Dr. Chambers holds a doctorate in psychology from John F. Kennedy University, and her dissertation research was on the function of drugs and alcohol in people with developmental and intellectual disabilities. Clinically, her experience is based in the public sector with a focus on people with serious mental illness, substance use, forensic involvement, and/or an intellectual disability.

STAFF ANALYSIS – ALAMEDA COUNTY

Innovation (INN) Project Name:	**Peer-Led Continuum for Forensic and Reentry Services**
Total INN Funding Requested:	**$8,692,893**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**January 25, 2023**

Review History:

Approved by the County Board of Supervisors:	June 13, 2022
Mental Health Board Hearing:	May 16, 2022
Public Comment Period:	April 1, 2022 through April 30, 2022
County submitted INN Project:	December 5, 2022
Date Project Shared with Stakeholders:	August 26, 2022, and December 5, 2022

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 as well as increase the quality of mental health services, including measured outcomes.

This Proposed Project meets INN criteria by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population consisting of mental health consumers who are involved in the criminal justice system.

Project Introduction:

The County is proposing to reduce criminal justice involvement for individuals living with mental health challenges through their Peer-Led Continuum – Forensic and Reentry Services innovation project. It will include four programs led by certified forensic peer specialists with lived experience and trained family members with the overarching goal of reducing incarceration and increasing mental health services participation and engagement.

The county has prioritized this project as part of the County's larger effort to address the high rates of criminal justice involvement for those living with mental health challenges.

What is the Problem:

Alameda County and community partners have made efforts to reduce incarceration of individuals living with serious mental illness and/or substance use disorders. In May 2021, Alameda's Behavioral Health Department developed and shared their Forensic and Reentry Services Plan, containing both short- and long-term steps to address reducing criminal justice involvement for this specific target population.

In September 2020, The County's Mental Health Task Force published a report based on stakeholder recommendations with emphasis on supporting reentry for individuals. Alameda's Behavioral Health also had embarked on research to develop a Forensic Mental Health and Reentry Plan, published shortly thereafter in October 2020. The Forensic Mental Health and Reentry Plan incorporated recommendations informed by the Mental Health Task Force along with evidence-based practices that aligned with County's strategic goals.

The County states the threshold to arrest and incarcerate an individual is lower than the threshold to engage an individual into mental health services and this triggers the use of jails being more readily available compared with in-patient recovery services. Once a person becomes involved with the criminal justice system, they are more likely to encounter this same system again rather than receive the needed mental health services.

This project offers to test the use of peer-led and family focused solutions to reduce incarceration for individuals living with serious mental illness and/or substance use disorders. The services offered in this project are created to be voluntary in nature.

How this Innovation project addresses this problem:

This project will offer a total of **4 service components, 3 are peer-led and 1 is family-focused** with the overarching goal of reducing incarceration for individuals living with mental health issues, with the hopes that participation in mental health services will increase:

1. Provision of support for mental health consumers who are justice-involved for reentry back into the community (*peer-led*)
2. Identifying and addressing factors that may have led to involvement with criminal justice system (*peer-led*)
3. Linkages to supports and services (*peer-led*)
4. Incorporating family members to advocate on behalf of the individual living with mental illness who is justice involved (*family-focused*)

These 4 service components will utilize **Reentry Coaches**, **WRAP for Reentry**, **Forensic Peer Respite**, and **Family Navigation and Supports** (see pgs 7-9 for details).

- Reentry Coaches – Forensic Peer Specialists will serve as Reentry Coaches, first points of contact upon release from jail, will assist individuals in developing a personalized reentry plan (including linkages for food and shelter, and transportation) with up to 90 days of direct peer support, and overall support and encouragement.
- WRAP for Reentry – Wellness Recovery Action Planning (WRAP) facilitators and Forensic Peer Specialists will receive training in WRAP for Reentry. Current certified WRAP facilitators will receive an 8-hour training session in WRAP for Reentry; Forensic Peer Specialists who are not WRAP facilitators will first receive training to become WRAP certified and will then proceed to receive the 8 hours of training in WRAP for Reentry.
- Forensic Peer Respite – will offer 24/7 peer support services in an unlocked, peer-led environment for individuals who may benefit from connecting with peers on their path to recovery after reentry and reduce recidivism. It is anticipated the length of stay may range from 5-14 days (potentially up to 30) for a total capacity of 6 individuals. The site for this location has yet to be secured **but will not be paid for with innovation funding** (see below for more information).
- Family Navigation and Support – informational materials will be developed and provided to family members of adult children to assist and advocate for their loved ones towards a path of recovery and reentry. Family partners will receive training and be available to educate and coach families to advocate on behalf of their loved ones and navigate the criminal justice system (types of hearings, the appeals process, how competency is determined, etc).

The County states this project is part of a larger effort in the County aimed at supporting individuals living with mental health challenges and are involved in the justice system. As a result, the County applied for and received funding from the Behavioral Health Community Infrastructure Program (BHCIP) to assist in recruiting, training, and certifying peers in forensics (pg 3).

The Community Program Planning Process

Local Level

Alameda County states this project was developed in partnership by their community and the County's Justice Involved Mental Health Task Force, which includes various members representing health care and behavioral health systems, provider and advocacy organizations, criminal justice professionals, consumers, and families, as well community and faith-based leaders.

After the release of the afore-mentioned reports, published separately, by the County's Mental Health Task Force as well as the Forensic Mental Health and Reentry Plan, the County then contracted with the Indigo Project to engage the community in identifying components of these two reports that may warrant continued research and development. Workshops were held where community partners and stakeholders provided ideas on how to best serve this population, including families of individuals living with mental health challenges who have had

previous interactions with the criminal justice system. Some of the partners and stakeholders involved in these workshops included consumer representatives, individuals and families from NAMI, behavioral health providers, members of African American subcommittee, and MHSA stakeholder group (see pg 16-17 for complete list). Discussions continued, resulting in the development of this project.

Alameda County's community planning process included the following:

- 30-day public comment period: April 1, 2022 through April 30, 2022
- Local Mental Health Board Hearing: May 16, 2022
- Board of Supervisor Approval: June 13, 2022

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 5, 2022.

Commission Level

This project was initially shared with Community Partners on August 26, 2022, and the final version was again shared on December 5, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

> *A comment was received on August 26, 2022, during the initial sharing of this project and offered support for this project and had specific questions for the County. Specifically, the individual requested to know if the services provided by this project would be available for City of Berkeley residents. The comment was forwarded to Alameda Behavioral Staff who then responded to Commission staff indicating that they would follow up with this individual directly. Emailed County on December 19, 2022, to follow up and County responded that they did reach out to this individual to discuss his questions.*
>
> *A comment was received from a member of the Client Family Leadership Committee (representing family members) on December 18, 2022, summarizing the project and providing their support for this project.*

Learning Objectives and Evaluation (pgs 12-15 of project):

The County indicates this project will serve approximately 2,279 individuals/families* per year between the following components of this project:

- Individuals served by Reentry coaches (480 individuals per year)
- WRAP for Reentry (960 individuals per year)
- Forensic Peer Respite (122 individuals per year)
- Family Navigation and Support Program (800 families)

** These amounts are all approximate values provided by the County*

The County has set forth specific learning questions for this project and will hire an external contractor to guide and complete the evaluation. The learning questions will assist the County in determining if these programmatic components, siloed or collectively, are effective in reducing criminal justice involvement for individuals living with mental health challenges with the use of Certified Peer Specialists.

The learning questions of this project, testing the utilization of Certified Peer Specialists, are as follows:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage (level of service), and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and are able to exit the criminal justice system?
4. To what extent do people who participate in INN-funded services experience increased service engagement and participation?
5. How does family education and consultation support individuals to move through the justice system?

The County hopes to learn if project outcomes reflect the following:

- Increased collaboration among County Behavioral Health providers and partners
- Reduced jail bookings and jail bed days
- Increase in the engagement and participation of mental health services
- Improvement in the experience of mental health and criminal justice system interactions
- Reduced criminal justice involvement for mental health consumers

The contracted evaluator may use a variety of measures to collect and analyze both quantitative and qualitative data including, but not limited to:

- Socio-demographic data (race/ethnicity, age, sexual orientation, housing status)
- Any previous criminal justice history and mental health diagnoses
- Referrals and linkages from mental health providers
- Court and Sheriff's Department records
- Interviews and focus groups
- Surveys of service recipients and their families

The Budget: *(see pgs 20-23)*

5 Year Budget	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Personnel	$ 329,833.00	$ 732,917.00	$ 1,136,000.00	$ 1,136,000.00	$ 1,136,000.00	$ 4,470,750.00
Direct Costs	$ 303,995.00	$ 528,040.00	$ 752,084.00	$ 752,084.00	$ 752,084.00	$ 3,088,287.00
Indirect Costs	$ 95,074.00	$ 189,143.00	$ 283,213.00	$ 283,213.00	$ 283,213.00	$ 1,133,856.00
						$ -
Total INN Funding Requested	$ 728,902.00	$ 1,450,100.00	$ 2,171,297.00	$ 2,171,297.00	$ 2,171,297.00	$ 8,692,893.00

Funding Source	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Innovation Funds Requested	$ 728,902.00	$ 1,450,100.00	$ 2,171,297.00	$ 2,171,297.00	$ 2,171,297.00	$ 8,692,893.00
Medi-Cal Reimbursement	$ -	$ -	$ -	$ -	$ -	$ 1,106,892.00
Total	$ 728,902.00	$ 1,450,100.00	$ 2,171,297.00	$ 2,171,297.00	$ 2,171,297.00	$ 9,799,785.00

Alameda County is seeking authorization to use up to **$8,692,893** in innovation funding over a five-year period.

- Personnel costs total **$4,470,750** (51.4% of the total project) and will cover costs and benefits for the following staff (*see page 22 for salary information*):
  - 1 Program Director
  - 5 Reentry Coaches
  - 3 WRAP Facilitators
  - 1 Program Manager
  - 8 Forensic Peer Specialists
- Operating costs consist of:
  - Direct Costs total **$3,088,287** (35.5% of total project) to cover costs associated with, but not limited to: rent, utilities, phone service, furniture, technology maintenance, transportation and mileage,
  - Indirect Costs total **$1,133,856** (13.0% of the total project) to cover costs that include, but not limited to administrative expenses to cover rent, utilities, staff benefits, insurance, and cost for staff to monitor contracts.
    - *Consultant/Contractor Costs have been incorporated within the Operating Costs and total $964,388 to cover services related to material development, recruitment and training, and legal counsel. Of the total consultant and contractor amounts indicated above ($964,388), there is a total of $431,685 (5% of the total project amount) allocated for the evaluation of this project.*

The County may potentially seek and receive Medi-Cal Reimbursements for this project in the amount of $1,106,892.

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

STAFF ANALYSIS – ALAMEDA COUNTY

Innovation (INN) Project Name:	**Alternatives to Confinement**
Total INN Funding Requested:	**$13,432,651**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**January 25, 2023**

Review History:

Approved by the County Board of Supervisors:	June 13, 2022
Mental Health Board Hearing:	May 16, 2022
Public Comment Period:	April 1, 2022 through April 30, 2022
County submitted INN Project:	December 5, 2022
Date Project Shared with Stakeholders:	August 26, 2022 and December 5, 2022

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 as well as increase the quality of mental health services, including measured outcomes.

This Proposed Project meets INN criteria by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population consisting of mental health consumers who are involved in the criminal justice system.

Project Introduction:

The County is proposing to reduce criminal justice involvement for individuals living with mental health challenges through the utilization of clinical staff and law enforcement participation to divert individuals for mental health assessments in lieu of arrest by utilizing a Forensic Crisis Residential Treatment Center, an Arrest/Diversion Triage Center along with a program to assist in reducing probation and parole violations.

The county has prioritized this project as part of the County's larger effort to address the high rates of criminal justice involvement for those living with mental health challenges.

What is the Problem:

Alameda County and community partners have made efforts to reduce incarceration of individuals living with serious mental illness and/or substance use disorders. In May 2021, Alameda's Behavioral Health Department developed and shared their Forensic and Reentry Services Plan, containing both short- and long-term steps to address reducing criminal justice involvement for this specific target population.

In September 2020, The County's Mental Health Task Force published a report based on stakeholder recommendations with emphasis on supporting reentry for individuals. Alameda's Behavioral Health also had embarked on research to develop a Forensic Mental Health and Reentry Plan, also published shortly thereafter in October 2020. The Forensic Mental Health and Reentry Plan incorporated recommendations informed by the Mental Health Task Force along with evidence-based practices that aligned with County's strategic goals.

The County contends the threshold to arrest and incarcerate an individual is lower than the threshold to engage an individual into mental health services and this triggers the use of jails being more readily available compared with in-patient recovery services. Once a person becomes involved with the criminal justice system, they are more likely to encounter this same system again rather than receive the needed mental health services.

This project offers to test proposed solutions to this problem that are led by clinical staff and participation by law enforcement to divert individuals from arrest to assessment in a triage center. The services offered in this project are created to be voluntary in nature.

How this Innovation project addresses this problem:

This project is led by clinical staff with the overarching goal of preventing incarceration of individuals with mental health challenges by diverting, assessing, and then engaging them to receive mental health services (see pgs 6-9) under the following conditions:

1. When a forensically involved mental health consumer begins to exhibit early crisis warning signs that may ultimately lead to police contact;
2. Any police contact that may result in an arrest;
3. When an individual is subject to re-arrest after being out of compliance with terms of probation or parole.

The site for this location has yet to be secured **but will not be paid for with innovation funding** (see below for more information). This project will offer the following three co-located services:

- **Forensic Crisis Residential Treatment Program** – this will serve as a 24/7 voluntary unlocked facility that may be used in lieu of booking into jail to re-stabilize the individual from reaching crisis point that would normally trigger law enforcement contact. Licensed as a Short-Term Rehabilitation Facility, it is anticipated individuals

may be able to stay between 5-14 days, up to a maximum of 30 days and has a maximum capacity of 16 beds. Referrals may come from mental health providers who provide services to justice-involved individuals living with mental health challenges, psychiatric hospitals, emergency rooms, crisis stabilization units, as well as the arrest diversion program (discussed below).

- **Arrest Diversion / Triage Center** – this will be an unlocked center for individuals who require a lower level of security and will be staffed 24/7 with case managers, clinical program managers and forensic peer specialists (trained in WRAP for Reentry, specific for individuals living with mental health challenges who are criminal justice involved). This center will be available for law enforcement officers to bring in an individual with a serious mental illness who would, under normal circumstances, be arrested and booked into jail.
- **Reducing Parole/Probation Violations Program** – this program will provide training and informational materials to providers who work with forensically involved mental health consumers to help offer support and resources for their clients with the goal of helping their clients comply with the terms and conditions of their probation or parole to avoid re-arrest.

The County applied for and received funding from the Behavioral Health Community Infrastructure Program (BHCIP) to assist in recruiting, training, and certifying peers in forensics that are being used in the Arrest Diversion/Triage Center described above.

The Community Program Planning Process

Local Level

Alameda County states this project was developed in partnership by their community and the County's Justice Involved Mental Health Task Force, which includes various members representing health care and behavioral health systems, provider and advocacy organizations, criminal justice professionals, consumers and families, as well community and faith-based leaders.

After the release of the afore-mentioned reports, published separately, by the County's Mental Health Task Force as well as the Forensic Mental Health and Reentry Plan, the County then contracted with the Indigo Project to engage the community in identifying components of these two reports that may warrant continued research and development. Workshops were held where community partners and stakeholders provided ideas on how to best serve this population, including families of individuals living with mental health challenges who have had previous interactions with the criminal justice system. Some of the partners and stakeholders involved in these workshops included consumer representatives, individuals and families from NAMI, behavioral health providers, members of African American subcommittee, and MHSA stakeholder group (see pg 16-17 for complete list). Discussions continued, resulting in the development of this project.

Alameda County's community planning process included the following:

- 30-day public comment period: April 1, 2022 through April 30, 2022
- Local Mental Health Board Hearing: May 16, 2022
- Board of Supervisor Approval: June 13, 2022

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on December 5, 2022.

Commission Level

This project was initially shared with Community Partners on August 26, 2022, and the final version was again shared on December 5, 2022. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

> *A comment was received on August 26, 2022, during the initial sharing of this project and offered support for this project and had specific questions for the County. Specifically, individual requested to know if the services provided by this project would be available for City of Berkeley residents. The comment was forwarded to Alameda Behavioral Staff who then responded to Commission staff that they would follow up with this individual directly. Note: Emailed County on December 19, 2022, to follow up and County responded that they did reach out to this individual to discuss his questions and provided needed information.*
>
> *A comment was received from a member of the Client Family Leadership Committee (representing family members) on December 18, 2022, summarizing the project and providing their support for this project.*

Learning Objectives and Evaluation (pgs 11-16 of project):

The County indicates this project is anticipated to serve the following number of individuals:

- Arrest Diversion Center (1,825 individuals per year)
- Forensic CRT Program (700 individuals per year)
- RP/PV Program (40 providers)

The County has set forth specific learning questions for this project and will hire an external contractor to guide and complete the evaluation. The learning questions will assist the County in determining if this project results in preventing jail bookings as well as the extent in which law enforcement is willing to divert individuals into the arrest diversion center rather than booking them into jail.

The learning questions for this project, utilizing clinical staff and law enforcement participation, are provided as follows:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage (what level of service), and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and parole/probation revocations?
4. To what extent do people who participate in INN-funded services experience increased service engagement and participation?
5. How does knowledge, understanding, and collaboration between mental health and criminal justice agencies change over the course of the project? What activities and experiences promote or detract from the working relationship?

The County hopes to learn if project outcomes reflect the following:

- Increased collaboration among County Behavioral Health providers and partners
- Reduced jail bookings and jail bed days
- Reduced parole and probation violations
- Increased criminal just system exits for mental health consumers
- Improved experience of justice and mental health systems interactions
- The contracted evaluator may use a variety of measures to collect and analyze both quantitative and qualitative data including, but not limited to: Socio-demographic data (race/ethnicity, age, sexual orientation, housing status)
- Any previous criminal justice history and mental health diagnoses
- Any participation in other programs or services with the County (i.e. residential and outpatient services)
- Previous and current criminal justice involvement (court dispositions, jail bookings, discharge dates)
- Referrals and linkages into other mental health services

The Budget: *(see pgs 21-24)*

5 Year Budget	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Personnel	$ 600,667.00	$ 1,092,833.00	$ 1,585,000.00	$ 1,585,000.00	$ 1,585,000.00	$ 6,448,500.00
Direct Costs	$ 674,187.00	$ 940,063.00	$ 1,205,940.00	$ 1,205,940.00	$ 1,205,940.00	$ 5,232,070.00
Indirect Costs	$ 191,228.00	$ 304,934.00	$ 418,641.00	$ 418,641.00	$ 418,641.00	$ 1,752,085.00
						$ -
Total INN Funding Requested*	$ 1,466,080.00	$ 2,337,831.00	$ 3,209,580.00	$ 3,209,580.00	$ 3,209,580.00	$ 13,432,651.00
**Dollar amounts are approximates to reflect total INN request of project*						

Funding Source	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	**TOTAL**
Innovation Funds Requested	$ 1,466,080.00	$ 2,337,831.00	$ 3,209,580.00	$ 3,209,580.00	$ 3,209,580.00	$ 13,432,651.00
Total	$ 1,466,080.00	$ 2,337,831.00	$ 3,209,580.00	$ 3,209,580.00	$ 3,209,580.00	$ 13,432,651.00

Alameda County is seeking authorization to use up to **$13,432,651** in innovation funding over a five-year period.

- Personnel costs total **$6,448,500** (48% of the total project) and will cover costs and benefits for staffing this project (*see pg 23 for all staff and salary information*):
    - Program Director/Clinical Supervisor (2); Program Manager (2), Clinician (5), Case Manager (6), Nursing (5), Forensic Peer Specialist (7), Therapist (2), Mental Health Rehabilitation Specialist (15)
- Operating costs consist of:
    - Direct Costs total **$5,232,068** (39% of total project) to cover costs associated with, but not limited to: rent, utilities, phone service, furniture, technology maintenance, transportation and mileage
    - Indirect Costs total **$1,752,085** (13% of the total project) to cover costs that include, but not limited to administrative expenses to cover rent, utilities, staff benefits, insurance, and cost for staff to monitor contracts.
        - *Consultant/Contractor Costs have been incorporated within the Operating Costs and total $2,178,369 to cover services related to licensing and certification, psychiatrist for the CRT, recruitment and training. Of the total consultant and contractor amount indicated above ($2,178,369), there is a total of $671,633 (5% of the total project amount) allocated for the evaluation of this project.*

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

AGENDA ITEM 9

Action

January 25, 2023 Commission Meeting

The Governor's 2023-2024 Proposed Budget,

The Commission's 2022-2023 Mid-Year Budget Report & Expenditure Authority

Overview of the Governor's proposed 2023 budget

Governor Gavin Newsom announced his Proposed $297 Billion State Budget on Tuesday, January 10, 2023. Although the state is forecasting a shortfall of $22.5 billion in the 2023-24 fiscal year, the Governor's Proposed Budget does not contain deep cuts to ongoing programs.

Key Investments include:

- Expanding the Behavioral Health Continuum
- Continuing Workforce Development
- Investments in Homelessness
- Opioid and Fentanyl Response

Health and Human Services

The Governor's 2023-24 Proposed Budget includes $230.5 billion for all health and human services programs. The Proposed Budget builds upon the last two Budget Acts, which includes investments to advance the health and well-being of all Californians and maintains most of the investments made in recent years.

Investment.

The Budget includes more than $8 billion in total funds spread across various Health and Human Services departments that expand the behavioral health treatment and infrastructure capacity and transform the system for providing behavioral health services to children and youth.

Delays

The Budget delays the last round of the behavioral health continuum capacity funding of $480.7 million appropriated in the 2022-2023 Budget Act by $240.4 million in 2024-25 and by $240.3 million in 2025-26. The Budget includes $480 million General Fund for crisis and behavioral health continuum grant funding to be awarded in 2022-23.

Expanding Behavioral Health

- **Expanding Health Care Access and Delivery System Transformation:** The Budget appropriates $844.5 million in 2023-24, $2.1 billion in 2024-25, and approximately $2.5 billion ongoing. Additionally, the Budget includes approximately $10 billion in a total fund-

commitment to continue transforming the health care delivery system through the California Advancing and Innovating Medi-Cal (CalAIM) Program.

- **California's Behavioral Health Community-Based Continuum Demonstration**: The Administration is currently seeking federal approval of CalBH-CBC Demonstration to expand behavioral health crisis, inpatient, and residential services through a staged implementation starting January 1, 2024. The fiscal impact for the Department of Health Care Services and Department of Social Services over the five years of the waiver is estimated to be $6.1 billion.
- **Community Assistance, Recovery & Empowerment (CARE) Act**: Maintains $88.3 million for county start-up and state implementation of the CARE Act and proposes additional funding for local assistance ongoing costs, including $16.5 million in 2023-24, $66.5 million in 2024-25, $108.5 million in 2025-26, and annually thereafter to support estimated county behavioral health department costs for the CARE Act.
- **Incompetent to Stand Trial Waitlist Solutions**: The Budget maintains $535.5 million in 2022-23, increasing to $638 million in 2025-26 and ongoing for the Department of State Hospitals.

Continuing Workforce Development

The Governor's proposed budget includes $1 billion to the Department of Health Care Access and Information to strengthen and expand the state's health and human services workforce to increase nurses, community health workers, and social workers, as well as support new individuals coming into the workforce in behavioral health. The 2022-23 Budget Act invested approximately $2.2 billion for continuing workforce development which included creating more innovative and accessible opportunities to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce. The current Proposed Budget reduces $55 million of these investments.

Investments in Homelessness

The Governor's proposed budget upholds commitments made in last year's 2022 Budget Act to invest an additional $1 billion to fund a fifth round of Homeless Housing, Assistance and Prevention grants for fiscal year 2023-24.

The proposed budget also details new accountability measures for local government for homelessness funding by prioritizing spending on specific programs and requiring adherence to state housing laws.

- **Homelessness Funding:** Maintains $3.4 billion to address homelessness as committed in prior budgets. This includes $400 million for the third round of encampment resolution grants and $1 billion for the fifth round of Homeless Housing, Assistance and Prevention grants.
- **Homelessness Funding Accountability and Transparency:** Proposes statutory changes to the HHAP program to prioritize spending on activities such as encampment resolution, Homekey operating sustainability, and Community Assistance, Recovery and Empowerment (CARE) Act housing supports.
- **Homelessness Funding Eligibility:** Seeks to condition eligibility for any future homeless-related grants and competitive programs through the Business, Consumer Services and Housing Agency and the Health and Human Services Agency, on compliance with state housing law.

- **CalAIM Transitional Rent Waiver Amendment** - The Budget includes $17.9 million in 2025-26, increasing to $116.6 million at full implementation to allow up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system and who are at risk of inpatient hospitalization or emergency department visits.
- **Behavioral Health Bridge Housing Program** - The Budget delays $250 million General Fund of the total $1.5 billion General Fund to 2024-25 for the Behavioral Health Bridge Housing Program. The Budget maintains $1 billion General Fund in 2022-23 and $250 million General Fund in 2023-24 for this program.

Other Health and Human Services Adjustments

Opioid and Fentanyl Response

Building on the 2022 Budget Act opioid response investments, the Budget includes an additional $93 million in Opioid Settlement Fund over four years beginning 2023-24. California has seen a significant increase in opioid and fentanyl-related deaths and the Governor's proposed budget includes resources to meaningfully address this issue.

- **Fentanyl Response:** Proposes $79 million for the Naloxone Distribution Project to increase distribution to first responders, law enforcement, community-based organizations, and county agencies.
- **Fentanyl Grants:** Proposes $10 million for grants to increase local efforts in education, testing, recovery, and support services to implement Chapter 783, Statutes of 2022 (AB 2365).
- **Fentanyl Test Strips:** Proposes $4 million to support innovative approaches to make fentanyl test strips and naloxone more widely available.
- **Fentanyl Impacts on Youth:** $3.5 million ongoing to provide all middle and high school sites with at least two doses of naloxone hydrochloride or another medication to reverse an opioid overdose on campus.

The Governor's 2023-24 budget proposal includes $47.9 million to the Commission.

The Governor's entire proposed budget can be accessed at https://www.ebudget.ca.gov/

Mid-Year 2022-23 Commission Budget Update

Summary: Each year, the Mental Health Services Oversight and Accountability Commission is presented with a mid-year report on the budget in January, which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provides a budget presentation in May, that coincides with the Governor's May Revision, and again in July at the beginning of the new fiscal year. The goal of these presentations is to support fiscal transparency and ensure that Commission expenditures are in line with the Commission's priorities.

Background:

The Commission's budget is organized into three main categories: Operations, Budget Directed, and Local Assistance.

- **Operations:** Includes Personnel and Core Operations. These funds are provided for staff, rent, and other related expenses needed to support the work of the Commission. Funding is usually ongoing with some exceptions such as one-time funding to support Commission directed initiatives.
- **Budget Directed:** Funding provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant programs with one-time and ongoing funding that is allocated over multiple fiscal years.
- **Local Assistance:** Includes the majority of Commission's funding that is provided to counties and other local partners. Funding is provided via grants to counties or organizations on an ongoing and/or one-time basis, spread over multiple fiscal years.

Budget by Fiscal Year and Specific Category

	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24
Operations				
Personnel	$5,528,000	$6,720,000	$8,100,000	$8,968,000
Core Operations	$5,256,000	$3,890,000	$3,168,000	$4,295,000
Total Operations	**$11,063,000**	**$10,610,000**	**$11,268,000**	**$13,263,000**
Budget Directed				
COVID-19 Response*	$2,020,000			
Covid 19/Suicide Prevention*	$2,000,000			
Anti-Bullying Campaign*		$5,000,000		
MHSSA Admin Augmentation*		$15,000,000		
MHSSA Admin/Evaluation*		$10,000,000	$16,646,000	
Evaluation of FSP Outcomes			$400,000	$400,000
Fellowship/Transformational Change*			$5,000,000	
Total Budget Directed	**$4,020,000**	**$30,000,000**	**$22,046,000**	**$400,000**
Local Assistance				
Children & Youth Behavioral Health Initiative*			$42,900,000	
Community Advocacy Partnership	$1,398,000	$5,418,000	$6,700,000	$6,700,000
Mental Health Student Services Act (MHSSA)**	$8,830,000	$188,830,000	$8,830,000	$7,606,000
Mental Health Wellness Act / Triage	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Total Local Assistance Funds	**$30,228,000**	**$214,487,000**	**$78,430,000**	**$32,306,000**
Grand Total	**$45,032,000**	**$255,097,000**	**$111,744,000**	**$47,969,000**

*one-time funds

**one-time funds and ongoing funds

Operations

- **Personnel:** In the 2023-24 Fiscal Year, the Legislature approved 2 full-time IT positions, thus creating an Information Technology and Security Unit at the Commission designed to keep up with the State's changing cyber landscape.
- **Core Operations:** The Commission's Core Operations shows a slight increase in the 2023-24 Fiscal Year due to a shift of funds from Local Assistance to Core Operations to better support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program.

Budget Directed

The Governor's Budget includes specific language that provides direction to departments on how funding can be spent. Funding is provided to engage diverse communities – including consumers and families from different cultural and social backgrounds, service providers, local governments, employers and others involved in the public and privately funded behavioral health systems – that drive changes needed to increase access to high quality services and improve outcomes.

Over the last three years, the Commission received funding for specific one-time projects displayed in the chart above. This year the Commission did not request additional funding for non-personnel budget requests and legislative proposals in the 2023-24 Fiscal Year .

- **Full-Service Partnerships:** $400,000 in ongoing funds to report the outcomes for those receiving community mental health services under full-service partnerships, to reduce incarceration, hospitalization, and homelessness, as required by Chapter 544, Statutes of 2021, Senate Bill 465.
- **Behavioral Health Fellowship:** $5 million in one-time funds to establish a behavioral health fellowship that is designed to drive transformational change and reduce racial, ethnic, and cultural disparities in mental health outcomes. The funds will be used to launch a partnership between the Commission and an academic institution. Through a competitive procurement process, the University of the Pacific has been awarded this contract. Contract negotiations are currently under way.
- **Mental Health Student Services Act Administration and Evaluation:** Fiscal Year 2022-23 includes $16,646,000 in one-time funds spread over five years, that support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program.

  Fiscal Year 2021-22 includes One-time funds of $10 million for MHSSA administration and evaluation and $15 million for MHSSA administration and augmentation, for a total of $25 million spread over five years to support the successful implementation and evaluation of the Mental Health Student Services Act Partnership Grant Program. The Commission received authority for 5 permanent positions for the next five years. These positions will support grants to 57 county mental health plans, regional collaboration meetings of grantees, information sharing, state reporting, evaluation of program effectiveness, and contract monitoring. Approximately $6.6 million is available for employee costs and $18.5 million for consulting and technical assistance contracts to support the program.
- **Anti-Bullying Campaign:** The Commission continues to implement a youth-focused anti-

bulling initiative that leveraged social media to support youth that was appropriated during the 2021-22 Budget Act. The project is part of a broader initiative targeting Anti-Asian hate. The Commission formed an advisory committee as directed in the budget to support this project.

The Commission entered into contract with an agency called Media Cause. Currently, Media Cause is nearing the completion of the discovery phase of their work, having done research, surveys, and interviews with youth and adult allies. The next steps will be to develop a comprehensive social media strategy leading into development and production.

- **COVID-19 Response:** In response to the COVID-19 pandemic, the Commission re-prioritized $2,020,000 in available funding that supports community response to growing mental health needs. In consultation with community advocates and county behavioral health leaders, the Commission focused its investment on addressing disparities and fortifying youth suicide prevention efforts in addition to offering general support.

  The Commission has invested $880,000 to strengthen school mental health strategies targeting social emotional learning and suicide prevention. The Commission entered into contracts with five non-profit providers to enhance the support they provide for schools. Due to the urgent mental health needs in the communities, these contracts were provided to subject matter experts, through a sole source process.

  The remaining funds were allocated through a sole source process, that supports improved opportunities for county behavioral health programs and that address disparities. The Commission has invested $1,140,000 in a project that supports the replication of a successful Solano County innovation project that targeted disparities reduction. Funding is available to provide technical assistance to counties to better understanding the work of the California Reducing Disparities Project and to replicate that work.

- **Covid 19/Suicide Prevention:** The Commission is implementing *Striving for Zero*, the State's suicide prevention strategic plan. The Budget Act of 2020-21 shifted funds in the Commission's existing budget allocation and provided $2 million to implement urgent aspects of the plan to consider impacts of the ongoing COVID-19 global pandemic.

  The Budget Act of 2021-22 established the Office of Suicide Prevention within the Department of Public Health to implement the *Striving for Zero* recommendations. The Commission's own implementation activities have included publication of a data dashboard to improve public awareness about deaths by suicide; linkage of public health vital statistics data with mental health client data to support further tracking and analysis of suicide deaths; and, execution of technical assistance contracts.

Local Assistance

The Commission manages grant programs that resource essential and innovative services in ways that incentivize stronger partnerships, integrated services, braided funding, and the evaluation required for continuous improvement. The Mental Health Wellness Act, youth drop-in centers, the early psychosis intervention (EPI), and the Mental Health Student Services Act are examples of such grants.

- **Community Advocacy Partnership Program:** The Mental Health Services Act calls for

ensuring that consumers, families, and people facing disparities are engaged in decision-making. The Commission provides Mental Health Services Act funds annually to support the voice of community members through advocacy contracts. Contracts are focused on community outreach and engagement, education and training, and state and local advocacy. The populations targeted with these funds include clients and consumers, diverse racial and ethnic communities, families, immigrants and refugees, LGBTQI+ populations, parents and caregivers, transition age youth, and veterans. In Fiscal Year 2021-22, the legislature approved new funding for K-12 contracts and additional funding for immigrant and refugee contracts. Currently funding for community advocacy contracts is $6.7 million annually.

- **Mental Health Student Services Act:** Established by Senate Bill 75, Chapter 51, Statutes of 2019 the Mental Health Student Services Act, provided $40 million in one-time and $10 million in ongoing Mental Health Services Act funds to implement partnerships between county behavioral health departments and local education agencies with the $10 million split between administration costs of $1.17 million and $8.83 million for grants. The Budget Act of 2021-22 augmented the Mental Health Student Services Act by adding one-time funding of $180 million for grants, and $25 million to support the implementation and evaluation of the program. Currently 57 school and county partnerships are receiving grants from the Commission intended for the betterment of student mental health.

  The Proposed 2023-24 budget shows a slight decrease in grant funding, as $1.2 million of annual funding has been moved from local assistance to state operations to support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program. The Commission is working to hire additional administrative staff to support the implementation of the Mental Health Student Services Act, develop a performance outcome monitoring system, provide consultation to grantees, Commission staff, and other partners, and conduct the evaluation to determine lessons learned, successful approaches, and additional needs of students.

- **Mental Health Wellness Act :** Senate Bill 82 established the Investment in Mental Health Wellness Act of 2013. The Commission receives $20 million each year to support the Mental Health Wellness Act, formerly known as Triage. The funding was originally only available to county behavioral health departments through a competitive process to support their crisis continuum of care and could only be used to hire staff. Due to these limitations, counties had a difficult time using the funds. In the Budget Act of 2022-23, legislative approved modifications to the Investment in Mental Health Services Act of 2013 included language that better addresses the underlying goals in the Act of improving crisis response, reducing hospitalizations and criminal justice involvement of mental health peers, and leveraging public and non-public sources of funding to improve access to care and wellbeing. The updated language allowed for these changes:

  1. Allow funding to be used for upstream crisis prevention and early intervention
  2. Expand uses beyond personnel grants
  3. Expand to allow partners other than counties
  4. Allow for non-competitive financing where appropriate

5. Eliminate the prohibition on matching funds

   Given the new bill language, current plans for the annual MHWA funds include $20 million for emPATH programs, $20 million for Agewise and Pearls programs which focus on mental health of older adults, and $20 million for programs focused on helping children aged 5 and younger.

- **Children and Youth Behavioral Health Initiative:** The Governor's 202-221 budget included $4.4 billion to support an array of projects that are intended to improve behavioral health outcomes for children. Those initiatives include $429 million designed to identify and replicate evidence-based practices focusing on early psychosis, youth drop-in centers, prevention and early intervention, reducing disparities, and meeting the needs of youth with complicated, high-end needs.

  The Budget Act of 2022-23 allocated $42.9 million to the Commission to support the identification and adoption of evidence-based practices. Commission Staff are currently working with the Health and Human Services Agency to finalize an interagency agreement for these funds.

Expenditure Authority

Details of the Commission's expenditure authority and associated contracts for 2022-23 are included in the PowerPoint Presentation.

Presenter: Norma Pate, Deputy Director

Enclosures: None

Handouts: PowerPoint slides will be made available at the Commission Meeting

The Commission will be presented with a mid-year update to the expenditure plan and associated contracts for 2022-23.

Proposed Motion: The Commission approves the Fiscal Year 2022-23 Mid-year expenditure plan and associated contracts.

MISCELLANEOUS ENCLOSURES

January 25, 2023 Commission Meeting

Enclosures (5):

(1) Sacramento County Innovation Project - Behavioral Health Crisis Services Collaborative Extension Request Letter, and Staff Analysis
(2) Evaluation Dashboard
(3) Innovation Dashboard
(4) Department of Health Care Services Revenue and Expenditure Reports Status Update
(5) 2023 Commission Meeting Dates (Tentative)

County Executive
Ann Edwards

Deputy County Executive
Chevon Kothari
Social Services

County of Sacramento

Department of Health Services
Timothy W. Lutz, Director

Divisions
Administration
Behavioral Health
Primary Health
Public Health

December 2, 2022

Toby Ewing, Ph.D.
Executive Director
Mental Health Services Oversight & Accountability Commission
1812 9th Street
Sacramento, CA 95811

RE: Sacramento County Request to Increase Behavioral Health Crisis Services Collaborative Innovation Project Budget

Dear Dr. Ewing:

Sacramento County Behavioral Health Services (BHS) is requesting to increase the Innovation (INN) funding for our INN 3: Behavioral Health Crisis Services Collaborative. The details of this request are included below.

INN 3: Behavioral Health Crisis Services Collaborative INN Project was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on May 24, 2018, in the amount of $13,885,361 for a four year term. The Project is a public/private partnership with Dignity Health and established a 24/7 integrated adult crisis stabilization service at Mercy San Juan hospital adjacent to the emergency department and includes a peer operated Resource Center. Outcomes include: improving behavioral health outcomes through a public/private collaboration and improving the integration of medical and mental health crisis stabilization services through a public/private partnership.

This INN project started on December 11, 2018 and began serving clients in September 2019. The original plan and primary purpose of this project remain unchanged. While the COVID-19 pandemic impacted capacity, the project saw increased staffing costs due to the 24/7 design of services, as well as hospital staffing requirements which impacted the budget and result

in a funding shortfall of approved INN funding to complete the evaluation of the project.

Therefore, BHS is requesting to increase the INN 3: Behavioral Health Crisis Services Collaborative project budget by $1,000,000 from $13,885,361 to $14,885,361 to cover the evaluation expenses. Sacramento will extend the duration of the project through February 2023 in order to allow for administrative time to complete the evaluation.

Community Planning Process
The INN 3 project was included in the BHS MHSA FY 2022-23 Annual Update which was posted for 30-day public review and comment from April 4 through May 4, 2022. The $2,831,963 INN 3 budget included in the Annual Update is inclusive of the MHSA INN funding increase requested.

The Mental Health Board conducted the Public Hearing on May 4, 2022, at the close of the comment period. During the posting period, the MHSA Steering Committee, Cultural Competence Committee and Mental Health Board reviewed the Annual Update and unanimously supported moving the Update forward to the Board of Supervisors for approval. The Annual Update was approved by the Board of Supervisors on June 14, 2022.

Additionally, BHS included the INN 3 project budget increase in the MHSA FY 2022-23 Plan Update (supplemental update), which was posted for 30-day public review and comment from August 19 through September 18, 2022.

BHS greatly appreciates consideration of this INN funding request. Please contact Jane Ann Zakhary, Division Manager, at zakharyj@saccounty.gov if you have any questions or need additional information.

Sincerely,

Ryan Quist, Ph.D.
Behavioral Health Director

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – Sacramento County

Innovative (INN) Project Name:	**Behavioral Health Crisis Services Collaborative (EXTENSION)**
Extension Funding Requested for Project:	**$1,000,000**

Review History:

MHSOAC Original Approval Date:	May 24, 2018
Original Amount Approved:	$13,885,361
Duration of INN Project:	4 Years

Current Request:

County Submitted INN Extension:	December 2, 2022
Extension Amount Request:	$1,000,000
Approved by BOS:	June 14, 2022
Consideration of INN Project:	December 2022

Project Summary:

Sacramento County's Behavioral Health Crisis Collaborative Innovation Project was originally approved for up to $13,885,361 in Innovation dollars on May 24, 2018. Through a partnership with Dignity Health and in collaboration with Placer County, Sacramento County established adult crisis stabilization and intensive mental health support services on a hospital campus (Mercy San Juan Medical Center) located in an underserved and high need section of Sacramento County.

Two Learning objectives guided the project:

Objective one

Is integrated and coordinated emergency medical and mental health crisis services provided through a public and private collaboration an effective strategy in removing existing barriers in accessing mental health crisis stabilization services? Do the services provided through a public/private partnership improve the quality and scope of crisis stabilization services, improve consumers' experience, and improve mental health outcomes for consumers?

Objective two

Does an interagency collaboration with shared governance and regulatory responsibilities improve the efficacy and integration of emergency medical and mental health crisis stabilization services?

Extension Request

Sacramento County is requesting up to an additional $1,000,000 in innovation funding to pay for unanticipated expenses associated with this project that resulted in an internal cost shift that the County would like to use Innovation funds to pay for.

The County entered a contract with Dignity Health in December 2018 but was unable to begin serving clients until September 2019 due to the time needed to build out the public-private partnership and design the program to meet the standards required by the hospital setting.

The program started serving clients in September 2019 and began experiencing the impacts of the COVID-19 pandemic six months later. The County reports reduced numbers of clients served during the pandemic to follow social distancing protocols while at the same time, experienced increased staffing costs due to hospital requirements and the 24/7 design of services.

Both the County and Dignity Health underestimated the cost of operating this program in the initial Innovation request as this was a new venture for both entities. Increased staffing costs occurred due to the hospital setting, requiring additional staffing ratios than the typical county standards and the need to staff nurses in addition to clinicians.

Because of the increased staffing costs, the County utilized more of the approved budget than expected requiring an internal shift in funds allocated for the evaluation to fund and finish out the service component of the project. The County now requests a funding increase to utilize Innovation to pay for the unexpected additional expenses.

This request will not change the project's direction, established learning objectives, or sustainability plan.

On December 2, 2022, the County also notified the Commission that they will extend the project duration through February 28, 2023 (two months) to allow for administrative time to complete required paperwork including the evaluation.

The Community Program Planning Process

The budget extension request was presented for 30-day public comment as part of the 2022-2023 Annual Update to the Three-Year Plan and Expenditure Report on April 4, 2022 and was approved by their local Mental Health Board on May 4, 2022. Please see page 154 of the Annual Update to locate the projected budget increase.

Sacramento County MHSA programming is informed by a 30-member Steering Committee. During the 30-day posting of the Annual Update, County Behavioral Health staff presented the plan details to the MHSA Steering Committee, Cultural Competence

Committee, and the Mental Health Board to obtain additional stakeholder input. County staff were supported to move the Annual Update to the board of Supervisors for approval.

The budget extension request was again presented for 30-day public comment as part of the 2022-2023 Plan Update on August 19, 2022.

The Commission shared the final version of this extension request with its community partner contractors, listserv, and Committees (CFLC and CLCC) on December 5, 2022. No comments were received in response to the Commission sharing the plan with these groups.

Recommendation:
Commission staff have no concerns regarding this request and recommend approval.

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the November Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 23,804.54
21MHSOAC023	$ 0.00
Total	**$ 0.00**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 TBD	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/21 - 06/30/24

Total Contract Amount: $5,414,545.00

Total Spent: **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	Yes
Quarterly Progress Reports	Not Started	03/31/2023	No
Quarterly Progress Reports	Not Started	06/30/2023	No

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	09/30/2023	No
Quarterly Progress Reports	Not Started	12/31/2023	No
Quarterly Progress Reports	Not Started	03/31/2024	No
Quarterly Progress Reports	Not Started	06/30/2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

JANUARY 2023

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	**TOTALS**
Number of Projects	12	13	**25**
Participating Counties (unduplicated)	11	8	**19**
Dollars Requested	$54,054,540.67	$58,492,082	**$112,546,622.67**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023	5	5	$13,138,081	5

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Santa Cruz	Healing The Streets	$5,735,209	5 Years	12/9/2021	Pending
Under Review	Orange	Clinical High Risk for Psychosis in Youth	$13,000,000	5 Years	2/26/2022	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	Pending
Under Review	Tuolumne	Family Ties: Youth and Family Wellness	$217,953	5 Years	8/22/2022	Pending
Under Review	Santa Clara	TGE Center	$17,298,034	54 Months	10/4/2022	Pending
Under Review	San Mateo	Mobile Behavioral Health Services for Farmworkers	$1,815,000	4 Years	10/27/2022	Pending
Under Review	San Mateo	Music Therapy for Asian Americans	$940,000	4 Years	10/27/2022	Pending
Under Review	San Mateo	Recovery Connection Drop-in-Center	$2,840,000	5 Years	10/27/2022	Pending
Under Review	San Mateo	Adult Residential In-Home Support Element (ARISE)	$1,240,000	4 Years	10/27/2022	Pending
Under Review	Contra Costa	Grants for Supporting Equity through Community Defined Practices	$6,119,182	4 Years	10/24/2022	Pending
Under Review	Fresno	The Lodge (EXTENSION)	$3,160,000	5 Years	12/2/2022	Pending
Under Review	Fresno	Impact of ACEs and Justice Involved	$2,200,000	3 Years	8/15/2022	Pending
Under Review	Marin	From Housing to Healing, A Re-Entry Community for Women	$560,300	5 Years	12/5/2022	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Alameda	Peer-led Continuum for Forensics and Reentry Services	$8,613,710	5 Years	7/25/2022	12/5/2022
Under Final Review	Alameda	Alternatives to Confinement	$13,432,651	5 Years	7/25/2022	12/5/2022
Under Final Review	Santa Barbara	Housing Retention and Benefit Acquisition	$7,552,606	5 Years	9/8/2022	12/22/2022
Under Final Review	Kings	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$3,203,101.78	5 Years	11/14/2022	12/23/2022
Under Final Review	Imperial	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$2,974,849	5 Years	12/5/2022	12/23/2022
Under Final Review	Mono	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$986,403	5 Years	11/14/2022	12/23/2022
Under Final Review	Placer	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$4,562,393	5 Years	11/14/2022	12/23/2022
Under Final Review	San Benito	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$4,940,202	5 Years	11/14/2022	12/23/2022
Under Final Review	San Joaquin	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$8,478,140	5 Years	11/14/2022	12/23/2022
Under Final Review	Siskiyou	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$1,073,106	5 Years	11/14/2022	12/23/2022
Under Final Review	Ventura	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$3,514,910	5 Years	11/14/2022	12/23/2022
Under Final Review	Sacramento	Behavioral Health Crisis Services Collaborative	$1,000,000	4.2 Years	12/2/2022	12/2/2022

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date
Napa	FSP Multi-County Collaborative	$844,750	10/11/2022
Sonoma	Semi-Statewide Enterprise Health Record	$4,420,447.54	11/17/2022
Tulare	Semi-Statewide Enterprise Health Record	$6,281,021	11/17/2022
Humboldt	Semi-Statewide Enterprise Health Record	$608,678	11/17/2022
Colusa	Social Determinants of Rural Mental Health (Extension)	$983,124	11/18/2022

DHCS Status Chart of County RERs Received
January 26, 2023, 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 January 6, 2023. This Status Report covers FY 2019 -2020 through FY 2020-2021, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2020-2021 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2020-21 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Alameda	1/29/2021	2/1/2021	2/8/2021	1/26/2022	2/3/2022	2/8/2022
Alpine	7/1/2021		10/15/2021	1/26/2022	2/3/2022	2/15/2022
Amador	1/15/2021	1/15/2021	2/2/2021	1/27/2022	2/3/2022	2/10/2022
Berkeley City	1/13/2021	1/13/2021	1/13/2021	2/1/2022	2/3/2022	3/1/2022
Butte	3/2/2022	3/2/2022	3/11/2022	8/11/2022	8/12/2022	8/15/2022
Calaveras	1/31/2021	2/1/2021	2/9/2021	1/31/2022	2/4/2022	2/8/2022
Colusa	4/15/2021	4/19/2021	5/27/2021	2/1/2022	2/4/2022	2/15/2022
Contra Costa	1/30/2021	2/1/2021	2/22/2021	1/31/2022	2/4/2022	3/11/2022
Del Norte	2/1/2021	2/2/2021	2/17/2021	1/28/2022	2/7/2022	2/23/2022
El Dorado	1/29/2021	1/29/2021	2/4/2021	1/28/2022	2/4/2022	2/9/2022
Fresno	12/29/2020	12/29/2021	1/26/2021	1/26/2022	2/7/2022	2/16/2022
Glenn	2/19/2021	2/24/2021	3/11/2021	3/21/2022	3/22/2022	4/6/2022
Humboldt	4/9/2021	4/13/2021	4/15/2021	8/15/2022	8/16/2022	8/24/2022
Imperial	2/1/2021	2/1/2021	2/12/2021	1/31/2022	2/4/2022	2/15/2022
Inyo	4/1/2021	4/2/2021		4/1/2022	4/12/2022	
Kern	2/2/2021	2/2/2021	2/8/2021	2/3/2022	2/7/2022	2/17/2022
Kings	1/4/2021	1/4/2021	3/11/2021	2/22/2022	2/22/2022	3/11/2022
Lake	2/9/2021	2/9/2021	2/17/2021	2/1/2022	2/8/2022	2/23/2022
Lassen	1/25/2021	1/25/2021	1/28/2021	2/2/2022	2/8/2022	2/17/2022
Los Angeles	3/11/2021	3/16/2021	3/30/2021	2/1/2022	2/7/2022	2/22/2022
Madera	3/29/2021	3/30/2021	4/15/2021	3/25/2022	3/29/2022	5/19/2022
Marin	2/2/2021	2/2/2021	2/17/2021	1/31/2022	2/7/2022	2/9/2022
Mariposa	1/29/2021	1/29/2021	3/11/2021	1/31/2022	2/7/2022	2/25/2022
Mendocino	12/30/2020	1/4/2021	1/20/2021	2/1/2022	2/7/2022	2/24/2022

DHCS Status Chart of County RERs Received
January 26, 2023 Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Merced	1/11/2021	1/12/2021	1/15/2021	1/27/2022	2/7/2022	2/8/2022
Modoc	4/29/2021	5/4/2021	5/13/2021	4/27/2022	4/28/2022	4/28/2022
Mono	1/29/2021	1/29/2021	2/16/2021	1/18/2022	2/7/2022	2/17/2022
Monterey	2/24/2021	3/1/2021	3/11/2021	2/2/2022	2/7/2022	2/9/2022
Napa	12/23/2020	12/24/2020	12/28/2020	2/7/2022	2/8/2022	3/3/2022
Nevada	1/29/2021	2/16/2021	2/18/2021	1/31/2022	2/2/2022	2/3/2022
Orange	12/31/2020	1/20/2021	2/9/2021	1/31/2022	2/3/2022	2/17/2022
Placer	2/3/2021	2/22/2021	2/23/2021	1/31/2022	3/17/2022	4/13/2022
Plumas	2/25/2021	3/19/2021	3/25/2021	7/14/2022	7/14/2022	11/29/2022
Riverside	2/1/2021	3/31/2021	4/8/2021	1/31/2022	2/4/2022	3/11/2022
Sacramento	1/29/2021	2/1/2021	5/6/2021	1/31/2022	2/3/2022	3/11/2022
San Benito	7/28/2021	7/30/2021	8/3/2021			
San Bernardino	3/3/2021	3/4/2021	3/17/2021	3/23/2022	3/23/2022	3/29/2022
San Diego	1/30/2021	2/1/2021	2/4/2021	1/31/2022	2/3/2022	2/18/2022
San Francisco	1/29/2021	3/19/2021	3/22/2021	1/31/2022		2/4/2022
San Joaquin	2/1/2021	2/2/2021	2/11/2021	3/22/2022	3/23/2022	3/25/2022
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021	1/26/2022	2/2/2022	2/7/2022
San Mateo	1/29/2021	2/1/2021	2/16/2021	1/31/2022	8/3/2022	8/4/2022
Santa Barbara	12/29/2020	12/30/2020	1/5/2021	1/26/2022	1/26/2022	2/10/2022
Santa Clara	1/28/2021	2/11/2021	3/3/2021	1/31/2022	2/15/20222	2/18/2022
Santa Cruz	3/29/2021	4/5/2021	4/15/2021	3/25/2022	3/25/2022	4/4/2022
Shasta	1/14/2021	1/15/2021	1/19/2021	1/25/2022	1/26/2022	2/10/2022
Sierra	12/31/2020	3/10/2021	4/12/2021	1/31/2022	2/2/2022	2/28/2022
Siskiyou	2/16/2021	6/11/2021	6/15/2021	7/18/2022	7/18/2022	8/10/2022
Solano	2/1/2021	2/1/2021	2/25/2021	1/31/2022	2/2/2022	2/8/2022
Sonoma	1/29/2021	3/5/2021	4/12/2021	1/31/2022	2/3/2022	2/22/2022

DHCS Status Chart of County RERs Received
January 26, 2023 Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Stanislaus	12/31/2020	1/5/2021	1/5/2021	1/31/2022	2/2/2022	2/15/2022
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021	2/9/2022	2/10/2022	2/15/2022
Tehama	4/27/2021	n/a	5/21/2021			
Tri-City	1/27/2021	3/4/2021	3/30/2021	1/31/2022	2/2/2022	5/25/2022
Trinity	2/1/2021	2/2/2021	2/17/2021	7/5/2022	7/5/2022	7/27/2022
Tulare	1/26/2021	1/27/2021	2/10/2021	1/31/2022	2/2/2022	2/10/2022
Tuolumne	6/2/2021	8/11/2021	8/11/2021	1/31/2022		2/4/2022
Ventura	1/29/2021	2/2/2021	2/16/2021	1/28/2022	2/2/2022	2/14/2022
Yolo	1/28/2021	2/2/2021	2/2/2021	1/31/2022	2/2/2022	2/2/2022
Total	**59**	**57**	**58**	**57**	**55**	**56**

Mental Health Services
Oversight & Accountability Commission

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2023 Commission Meeting Dates (Tentative)

January 25-26th
February 23rd
March 23rd
April 27th
May 25th
June (tentatively no meeting)
July 27th
August 24th
September 28th
October 26th
November 16th
December (tentatively no meeting)