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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
November 17, 2022
9:00 AM – 1:30 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

NOVEMBER 17, 2022

NOTICE IS HEREBY GIVEN that the Commission will conduct a Regular Meeting on **November 17, 2022, at 9:00 a.m.** This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123 and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

Date: November 17, 2022

Time: 9:00 AM – 1:30 PM

Location: MHSOAC
1812 9th Street
Sacramento, California 95811

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

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/81957890575
Meeting ID: 819 5789 0575

FOR PHONE DIAL IN
Dial-in Number: 408 638 0968
Meeting ID: 819 5789 0575

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 any additional meeting locations.

Our Commitment to Excellence

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

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Commission Meeting Agenda

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

9:00 AM **1.** **Call to Order & Roll Call**

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

9:05 AM **2.** **Announcements** ***Information***

Chair Mara Madrigal-Weiss will lead announcements and the Commission will honor former Commissioner Ken Berrick and Chair Emeritus Lynne Ashbeck for their dedication and service to the Commission.

10:05 AM **3.** **September 22, 2022 & October 27, 2022 Meeting Minutes** ***Action***

The Commission will consider approval of the minutes from the September 22, 2022 and October 27, 2022 Commission Meeting.

- Public Comment
- Vote

10:15 AM **4.** **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.

10:45 AM **5.** **Election of the 2023 MHSOAC Chair and Vice-Chair** ***Action***

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

- Public Comment
- Vote

11:15 AM **6.** **Break**

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

11:30 AM **7.** **Semi-Statewide Enterprise Health Record Multi-County Innovation Project** ***Action***

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

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

Presented by Sharmil Shah, Psy.D, Chief of Program Operations

This Agenda Item was presented at the October 27, 2022 Commission Meeting.

- Public Comment
- Vote

11:45 AM **8.** **Commission's Racial Equity Plan** ***Action***

The Commission will consider approval of the Commission's Racial Equity Plan; *presented by Anna Naify, Psy.D, Consulting Psychologist and Lauren Quintero, Chief of Administrative Services.*

This Agenda Item was presented at the October 27, 2022 Commission Meeting.

- Public Comment
- Vote

12:00 PM ***9.*** **Commission's Innovation Implementation Plan** ***Action***

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; *presented by Sharmil Shah, Psy.D, Chief of Program Operations.*

This Agenda Item was presented at the October 27, 2022 Commission Meeting.

- Public Comment
- Vote

12:15 PM **10. K-12 Student Advocacy Funding Outline** ***Action***

The Commission will hear a presentation on funding for K-12 Advocacy grants; *presented by Tom Orrock, Chief of Community Engagement.*

- Public Comment
- Vote

12:45 PM **11. The Mental Health Wellness Act & Older Adults** ***Action***

The Commission will hear a presentation on how Mental Health Wellness Act funds can support California's Master Plan on Aging; *presented by Susan DeMarois, Director, California Department of Aging*.

- Public Comment
- Vote

1:30 PM **12. 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 3

Action

November 17, 2022 Commission Meeting

Approve September 22 and October 27, 2022 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the September 22 and October 27, 2022 Commission teleconference meetings. 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 amendments are not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) September 22, 2022 Meeting Minutes; (2) October 27, 2022 Meeting Minutes

Handouts: None.

Proposed Motions:

- The Commission approves the September 22, 2022 meeting minutes.
- The Commission approves the October 27, 2022 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date September 22, 2022

Time 9:00 a.m.

Location 1812 9th Street
Sacramento, California 95811

Members Participating:

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

*Participated remotely.

Members Absent:

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

MHSOAC Meeting Staff Present:

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

1: Call to Order and Roll Call

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

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

Amariani Martinez, Commission staff, reviewed the meeting protocols.

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

2: Announcements and Committee Updates

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

Chair Madrigal-Weiss gave the announcements as follows:

Announcements

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

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

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

Staff Changes

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

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

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

Committee Updates

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

Children's Committee

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

Client and Family Leadership Committee Update

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

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

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

Cultural and Linguistic Competency Committee Update

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

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

Impact of Firearm Violence Subcommittee Update

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

Prevention and Early Intervention Subcommittee Update

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

Research and Evaluation Committee Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Comment. There was public comment.

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

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

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

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

The following Commissioners abstained: Commissioner Brown and Rowlett.

ACTION

5: Early Psychosis Programs (Action)

Presenters:

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

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

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

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

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

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

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

Commissioner Comments & Questions

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

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

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

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

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

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

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

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

Commissioner Carnevale stated the need for early intervention is massive.

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Presentation, continued</u>

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

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

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

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

Commissioner Comments & Questions

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

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

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

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

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

Commissioner Danovitch seconded.

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

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

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

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

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

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

Public Comment

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

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

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

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

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

Commissioner Discussion

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

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

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

Commissioner Tamplen asked if communities of color will be prioritized.

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

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

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

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

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

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

The following Commissioner abstained: Commissioner Chambers.

Commissioner Bunch rejoined the meeting.

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

Presenters:

- Toby Ewing, Executive Director

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

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

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

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

Commissioner Comments & Questions

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

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

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

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

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

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

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

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

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

Commissioner Danovitch made a motion to approve the staff recommendation.

Commissioner Carnevale seconded.

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

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

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

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

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

Public Comment

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

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

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

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

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

Commissioner Discussion

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

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

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

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

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

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

The following Commissioner abstained: Commissioner Rowlett.

7: <u>Break</u>

Due to time constraints, no break was taken.

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

Presenters:

- Toby Ewing, Executive Director

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

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

Commissioner Comments & Questions

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

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

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

Public Comment

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

Commissioner Discussion

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

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

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

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

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

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

Presenters:

- Tom Orrock, Chief, Community Engagement and Grants

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

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

Commissioner Comments & Questions

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

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

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

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

Public Comment. There was no public comment.

Commissioner Discussion

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

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

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

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

ADJOURNMENT

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

Mental Health Services
Oversight & Accountability Commission

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date October 27, 2022

Time 9:00 a.m.

Location 1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, Chair*
Sheriff Bill Brown
Steve Carnevale*
Shuo Chen*
Senator Dave Cortese*
Itai Danovitch, M.D.*
Gladys Mitchell*
Khatera Tamplen

*Participated remotely.

Members Absent:

Mayra Alvarez, Vice Chair
Mark Bontrager
John Boyd, Psy.D.
Keyondria Bunch, Ph.D.
Assembly Member Wendy Carrillo
Rayshell Chambers
David Gordon
Alfred Rowlett

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
Anna Naify, Psy.D., Consulting Psychologist
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
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:09 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 stated a quorum was not achieved.

2: Announcements and Committee Updates

Chair Madrigal-Weiss gave the announcements as follows:

Announcements

- The September 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 November 17th in Sacramento.
- Two fellowship positions have been posted. Named after Sally Zinman and Rusty Selix, the Peer Consumer and Mental Health Clinician Fellows will apply their expertise and background to all aspects of the Commission's work. More information can be found on the Commission website or at calhr.ca.gov.
- Two new Deputy Director positions, Deputy Director of Legislation and Deputy Director of Operations, will become available at the Commission. More information can be found on the Commission website or at calhr.ca.gov.
- Through delegated authority, Napa County was approved to join the FSP Multi-County Collaborative innovation project. The project was shared with the Commission's listserv, community partner contractors, and the CLCC and CFLC Committees on August 11th and September 2nd. No public comments were received. Documents were included in the meeting materials and on the website.

New Staff

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

Lauren Quintero, Chief, Administrative Services, stated two new staff have joined the Commission since the last Commission meeting. She introduced Brittany Scangarello and Rachel Rausch.

On behalf of the Commission, Chair Madrigal-Weiss welcomed Brittany Scangarello and Rachel Rausch to the Commission.

Committee Updates

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

Children's Committee

Chair Madrigal-Weiss stated the Children's Committee will meet on November 8th. More information will be posted on the website.

Client and Family Leadership Committee Update

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

- The CFLC last met on October 25th, heard an update on the Peer Certification Resource Guide, and discussed next steps including opportunities to scale peer services statewide and how the state can incentivize peer support services.
- The goal is to complete the Peer Certification Resource Guide by the end of the year.
- The Committee heard public comment and discussed feedback on the Commission's second draft of the prevention and early intervention report, *Well and Thriving*, led by Stacie Hiramoto, Executive Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO).
- Feedback received was that there should be a focus on college-age youth, as opposed to just college students, and that the report should specifically call out community-defined, evidence-based practices as a strategy to reduce disparities.
- The next CFLC meeting will take place on Tuesday, November 15th. The Committee will hear an update and provide input on the Peer Certification Resource Guide, hear more Committee feedback on PEI priorities, and hear an update from the California Mental Health Services Authority (CalMHSA) on the peer certification process, specifically about barriers that exist in grandparenting in peer providers who were previously providing services in the mental health system. The Committee will also discuss applications to the CFLC.

Cultural and Linguistic Competency Committee Update

Tom Orrock, Chief, Community Engagements and Grants Division, provided an update of the work of the Cultural and Linguistic Competency Committee (CLCC) since the last Commission meeting for Vice Chair Alvarez, Chair of the CLCC, who was unable to be in attendance.

- The CLCC last met on October 18th and heard a presentation from the Commission's Prevention and Early Intervention Subcommittee staff on the second draft of the prevention and early intervention report, *Well and Thriving*. CLCC Members were given the opportunity to provide additional input and feedback on the draft report and to respond to discussion questions developed in response to feedback received.
- The next CLCC meeting will take place on Thursday, November 10th. The Committee will hear a presentation on the progress the Committee has made this year.

Prevention and Early Intervention Subcommittee Update

Chair Madrigal-Weiss, Chair of the Prevention and Early Intervention (PEI) Subcommittee, provided a brief update of the work of the Subcommittee since the last Commission meeting:

- The Subcommittee released the first draft of its project report on August 24th. The Subcommittee met on September 7th and October 6th to hear feedback.
- The CFLC and CLCC discussed the draft.
- The Subcommittee will work with staff on the next revision of the draft. The revised version is planned to be released before the Thanksgiving holiday. More information will be provided on the website.

Research and Evaluation Committee Update

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

- The Committee heard a presentation from Commission staff on the fiscal transparency dashboard work for other state agencies at a Tableau gathering in Sacramento.
- Melissa Martin-Mollard, Director, Research and Evaluation Division, was invited by the California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) to present at their quarterly meeting, where she solicited initial feedback on core metrics for school mental health.
- MHSSA evaluation: The team participated in a site visit to Marin County's Wellness Center and is planning to visit additional sites to help inform the evaluation of the MHSSA.
- Next month, two Research Scientist Supervisor positions will be posted. These positions will help lead the MHSSA and full-service partnership (FSP) evaluation efforts.
- A Research and Evaluation MHSSA Workgroup will take place on December 16th. Details will be posted on the website.

3: General Public Comment (Information)

Richard Cornelius, Less Robertson, and Ricky Johnson, 100 Black Men of Sacramento, introduced their organization and stated they look forward to working with the Commission in the future to make a difference in the community through mentoring opportunities. Richard Cornelius, the President of 100 Black Men of Sacramento, noted that their organization is part of 100 Black Men of America.

Miya Bray, Intern, REMHDCO, thanked Commissioners for meeting with REMHDCO to discuss the California Reducing Disparities Project (CRDP) and for providing the platform to discuss this item at the last CFLC meeting. Meetings to discuss PEI priorities are scheduled in November.

Hector Ramirez, consumer, Los Angeles Department of Mental Health, stated they have not been to a Commission meeting in person for almost three years, due to the COVID-19 pandemic. Inequities in the system were highlighted during this period. The speaker stated they reached out to each Commissioner during the pandemic to advocate for their family and community, but those individuals died trying to be heard. The speaker stated the lack of accessibility, including language accessibility, during the pandemic cost lives.

Hector Ramirez stated youth in the community are trying to commit suicide due to the lack of services, accountability, and oversight in Los Angeles County. Advocates have been demanding that the Los Angeles Department of Mental Health be transparent with their Mental Health Services Act (MHSA) funding. Advocates have reached out to the MHSOAC Executive Director for assistance and did not receive information, and yet advocates have heard from the Steinberg Institute that there is over $1 billion of unspent MHSA funding that could have been used to save the lives of loved ones. This did not happen; instead, that funding continues to be utilized and allocated behind closed doors without a community engagement process. Commissioners are representatives of some organizations that did receive funding.

Hector Ramirez asked, in mourning and recognition of the people who have died during the COVID-19 pandemic while trying to reach out to each Commissioner to ask for help, to listen to them just as much as the Commission's advocate for suicide awareness, to also have recognition of those circumstances that led for those people to die. The two-spirit community is completely underfunded throughout the set of California initiatives. The Latino community, the majority of residents of the state of California, are treated as a minority. This morning was an example of the lack of accessibility that has perpetuated this Commission since it was established. As a former member of many Committees, the speaker stated they attended meetings in good faith but were not afforded their requested accommodations, which are legally required by federal and state laws. The speaker stated they were invited but not welcome. Today is a conversation of reckoning for individuals who died during those years, for individuals who are trying to stay alive, and those who will die today while there is a lack of access to Commissioners at the table.

Joey Espinoza, Imperial Valley LGBT Resource Center (IVLGBTRC), stated the county behavioral health services works in partnership with IVLGBTRC to provide services to

the LGBTQ community as well as domestic violence and anger management classes. The speaker asked for accountability and support. The behavioral health services in the Imperial Valley needs funding to better address inequities in the LGBTQ community. They need funding to train staff because it is inhumane to make people go through the disrespect and trauma of being misgendered, erased, and mistreated when seeking mental health services while they are already in a vulnerable state. The speaker requested that the allocation and execution of behavioral health services funds be closely overseen and Board be held accountable.

Joey Espinoza stated the Imperial Valley has a substance misuse epidemic. Rehabilitation services are sparse, and communities have difficultly accessing services for mental health, housing, employment, etc. The majority of the unsheltered population are dealing with immigration status issues on top of dealing with survival overall. City shelters are few and have limited capacity in the speaker's area, which experienced temperatures in the 110s and 120s this year. Public transportation is problematic and inaccessible to many individuals. Basic needs are tied in with mental health. The speaker asked for funding and for more rehabilitation centers and shelters for the unhoused population in the Imperial Valley.

Richard Gallo, consumer and advocate, former peer counselor, and Volunteer State Ambassador, Cal Voice ACCESS California, asked the Commission to review peer support services. Peer training is happening throughout the state getting ready for the certification and Medi-Cal billing. The speaker stated the need to increase peer services throughout the state, including peer respite programs.

Richard Gallo stated they sent a question via email to the Commission's human resources staff person regarding the benefits package for the peer specialist fellowship position but had yet to receive a response. This is unprofessional.

Jaime Yan Faurot, BIPOC Peer and advocate, stated the need to raise awareness of what is needed to help and support peers. She asked the Commission to consider including peers of color from BIPOC communities. One size does not fit all. Everyone is different and unique in their own representation and intersectionality. She provided the example that the AAPI community experiences marginalization and there is no name for the word "peer" in mental health support. She stated the need to find a way to better serve communities such as overcoming language barriers and cultural stigma. Simply speaking out is stigmatizing in her culture. One peer will not be successful for all communities. She stated she has reached out to Commission staff but has not received a response. She stated her chief objective of speaking today is to bring the voice of those who have been silenced so that they can have representation. There is a great need for peer roles in the making, especially BIPOC peers. She implored the Commission to consider more roles for different representation and intersectionality.

4: <u>September 22, 2022, Meeting Minutes</u> (Action)

Chair Madrigal-Weiss stated the Commission will be unable to approve the minutes due to the lack of a quorum. She asked for questions or comments on the minutes from the September 22, 2022, Commission meeting.

Public Comment.

Hector Ramirez stated it is concerning considering that the state of California is in the middle of a mental health epidemic, particularly for youth. The state is also in the middle of out of the largest homeless epidemics in the world. The speaker noted that, although the Governor stated this week that California is poised to be one of the richest economies in the world, the important work that needs to done to help communities cannot happen because individuals are not present. This must be a call to action internally and externally. Members of the public have come from all over California to engage this Commission. Internal problems need to be addressed with staff so Commissioners have the support to attend Commission meetings in order to do the business that needs to be done.

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

Chair Madrigal-Weiss tabled this agenda item to the next meeting due the lack of a quorum.

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

Presenter:

- Amie Miller, Psy.D., Executive Director, California Mental Health Services Authority (CalMHSA)

Chair Madrigal-Weiss stated the initial draft of this project was shared with the Commission's listserv on September 27, 2022, and the final draft was shared with the listserv, community partner contractors, CLCC, and CFLC on October 12, 2022. Three comments in support were received and highlighted in the staff analysis; one letter in opposition was received and was included in the meeting materials.

Chair Madrigal-Weiss stated the Commission will be unable to consider approval of innovation funding for this agenda item due to the lack of a quorum. The Commission will hear a presentation on CalMHSA's Semi-Statewide EHR Multi-County Innovation Project and about the following counties that are asking to join the project:

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

Chair Madrigal-Weiss asked the CalMHSA representative to present this agenda item.

Amie Miller, Psy.D., Executive Director, CalMHSA, provided an overview, with a slide presentation, of the concept, hierarchy of needs, vision, evaluation, budget, and community planning process of the Semi-Statewide Electronic Health Record Innovation Project.

Commissioner Comments & Questions

Commissioner Tamplen asked if the new codes for Peer Support Services and Family Peer Support Services will be included in this project.

Dr. Miller stated CalMHSA is helping implement the peer benefit across the state and is acutely familiar with the codes. The new system that will go live on July 1, 2023, will have the new Current Procedural Terminology (CPT) codes in a role-based configuration so individuals will only see pertinent service codes for easier billing in the system.

Dr. Miller stated CalMHSA heard through community engagement that the EHR poses a significant barrier to many peer support specialists to enter the Medi-Cal benefit. In response to this concern, CalMHSA has brought in components such as voice recognition software that will make it an easier process for peers to document.

Commissioner Carnevale agreed that, until the system is made more effective and efficient, needs that are desperately required will never be met. He asked if this project is the first step in a many-step process.

Dr. Miller stated this project is a foundational project. CalMHSA is taking care of the back-end business solutions so individuals can be free in their community to deeply engage and produce solutions that make sense for their unique community. This foundational offering will put California in a position to compare outcomes across counties so that communities can innovate in ways that do not take so long. Standardizing the data and collection processes and making a clinical workflow that makes sense and can be followed will allow outcomes to be measured properly.

Commissioner Carnevale suggested stating the percentages as the number of individuals that can be served in a particular kind of way as an example to underscore and to provide a better understanding of the importance of this work.

Commissioner Mitchell asked about the priority of work that has been done and first outcome goals for this project.

Dr. Miller stated CalMHSA is teaching counties to prioritize coding issues in a standardized “problem list” for inoperable physical health care in 2022 over filling out outdated forms that vary widely between counties. It is inappropriate that county staff spend large percentages of their time on documentation. CalMHSA’s first deliverable will be to codify the most important issues and how to solve them in order to help advocate for the most vulnerable individuals in California. Cleaning up the EHR and bringing it in alignment with physical health is the first goal. Once that is done, counties will then be able to innovate. CalMHSA is coordinating on behalf of counties, double-checking with the state, vetting this workflow, and bringing a minimalistic product forward.

Public Comment

Hector Ramirez stated one of the biggest problems for this Commission is realizing who the interested parties are. The speaker asked if the interested parties are parents, businesses trying to get a contract, employees, or the authentic interested parties such as individuals who try to get services and who do not work for any agency highlighted in

this proposal. The speaker asked CalMHSA to include the number of authentic interested parties who were part of the community engagement process in their report, such as the number of individuals with a severe persistent mental illness, and how they were included in the work.

Dannie Cesena, Director, California LGBTQ Health and Human Services (HHS) Network, stated the California LGBTQ HHS Network and #Out4MentalHealth project partners have generated reports and gathered input and feedback in listening sessions from communities across the state of California where access to mental health care is nonexistent. Often community members are misgendered and misnamed even as they fill out their paperwork, since EHRs have no room to denote legal name versus authentic name or to document how to refer to patients in person or when contacting them for appointments. Misgendering and misnaming causes the community to not want to seek out mental health services. This increases disparities, suicidality, depression, substance use, etc. Access to mental health starts at the first step respectful address.

Dannie Casena stated the other issue is the lack of data in communities. This new EHR provides an opportunity to ensure that sexual orientation and gender identity (SOGI) data is being captured. This data cannot be provided because it is not being collected. The speaker stated the need for the LGBTQ community to be kept in mind as these systems are being built.

Chair Madrigal-Weiss stated legal name versus authentic name and SOGI data issues have continuously come up. She asked if the proposed projects address these issues.

Dr. Miller stated CalMHSA asked the RAND Corporation to do a full federal landscape analysis to look at the best way to codify all of these things to be in alignment with interoperability standards. These have been built into the EHR.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, suggested posting the details to this project beyond today's presentation. The speaker stated the need to learn about the number of individuals who attended community engagement events, as well as the number of individuals who were county staff providers associated with the project, family members, and system users. The speaker asked why a representative from Medi-Cal is not in attendance to ensure that codes and requirements are addressed correctly.

Steve McNally stated their experience with the system is more that the psychiatrists do not want to treat families and they hide behind the Health Insurance Portability and Accountability Act of 1996 (HIPAA) law, even though the U.S. Health and Human Services has said this does not necessarily have to be an issue.

Steve McNally asked about the other 23 counties. The speaker asked how this project will be interoperable to these counties and if the counties that did the community planning have EHRs.

Steve McNally stated concern that CalMHSA is in charge of a project as a captive arm of the behavioral health directors, when they are not transparent and are not easy to track. The Tech Suites Peer Certification Projects have been difficult and almost impossible, they still are confusing to people in the state, they would not focus on implementation, and providers who received contracts were on the special council.

More scrutiny is needed. Trust from the state to the counties and counties to the communities is broken in the state.

Anna stated the need for the minimized documentation to support and empower rather than hinder the client recovery process. She suggested including peer support specialist advocates when looking at the language during the development process, not as an afterthought. This will allow humanizing the language and make it easier for everyone. It is important to ensure that the system is user-friendly.

Jaime Yan Faurot stated there is a major disconnection between the peer lead and the tech lead. She stated it sounds like the goal is for the project to value and to be driven by peers. She asked, if that is the case, why the information is not sharable between the two leads. She shared her experience of wanting to be a part of a meeting but, because she was a volunteer, she was stigmatized. She asked to attend a meeting but stated she had no means to get there and was told to ask her county. When she asked her county, the county told her to ask CalMHSA. She asked where the support is for interested parties. She stated she speaks six languages and yet she still encounters cultural stigma and linguistic barriers. Speaking six languages is still not adequate enough to connect because there is no information to correlate. She asked how to connect more when people do not speak the same language and for people with physical disabilities. There are broken pathways to help peers. She asked to connect with staff to further discuss these issues.

Mark Karmatz, consumer and advocate, asked why CalMHSA is using the RAND Corporation. There was a lot of trauma during the Vietnam War due to the research done by the RAND Corporation.

Dr. Miller stated there are many different factions of RAND and they have evolved over the last few years. There is a branch of RAND that deeply understands behavioral health that CalMHSA works carefully and closely with. RAND knows the language and the data behind the problems to be solved.

7: <u>Break</u>

Due to time constraints, no break was taken.

8: <u>Commission's Racial Equity Plan</u> (Action)

Presenters:

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

Chair Madrigal-Weiss stated the Commission joined 37 other state agencies in the Capitol Collaborative on Race and Equity (CCORE) approximately 2 years ago. Commission staff participated in trainings and learning from a consultant to enhance internal operations to support racial equity. At the August 2021 and March 2022 Commission meetings, the Commission heard presentations on the progress and areas of opportunity related to developing a Racial Equity Plan. Since then, staff have met with the CLCC, Commissioners, and other community partners to continue to gather

feedback and enhance the plan. The Racial Equity Plan provides the opportunity to leverage strategies identified in the Commission's strategic plan and to begin to address structural racism in California's mental health system.

Chair Madrigal-Weiss stated the Commission will hear a presentation from staff on the Racial Equity Plan but will be unable to vote on this item due to the lack of a quorum. She asked staff to present this agenda item.

Anna Naify, Psy.D., Consulting Psychologist, and provided an overview, with a slide presentation, of the background, Racial Equity Plan outline, and prioritizing equity in the Commission's work. Dr. Naify stated the need to centralize race and health equity in the work as an essential component in addressing the needs of the mental health system.

Lauren Quintero, Chief, Administrative Services, continued the slide presentation and discussed policy changes and cultural shifts, key features of the CCORE, and work to date.

Commissioner Comments & Questions

Chair Madrigal-Weiss asked for an example of using the Racial Equity Plan in the Commission's communications.

Dr. Naify stated the Commission has a contract with Crossroads Media as a way to reach communities in diverse languages. One of the ways to use the Racial Equity Plan is in contracting and using diverse media outlets to reach diverse communities.

Executive Director Ewing stated the intent is to be explicit and intentional in the work that the Commission is doing throughout all its functions. Communication gives the Commission multiple paths to embrace diversity and equity inclusion through communication efforts so that the communications done are more responsive to the diverse population of California, such as providing access to materials in diverse languages and developing the website in ways that it is translated to better reflect the needs of communities. Also, the kinds of narratives being developed, the storytelling, the representation around stigma, and public engagement can also be intentional in terms of being more reflective of the diversity of California's population. Recent communication work of the Commission includes supporting and participating in the development of the Hiding in Plain Sight documentary, working with school organizations to disseminate screenings of the film, and putting panels together. The whole point of the Racial Equity Plan is to be explicit, to learn, and to get better over time.

Public Comment

Hector Ramirez stated equity is a significant barrier, even within the Commission. The reason that the Governor signed the bill was because of the example of the lack of equity at the Commission and other agencies. The acronym DEI (diversity, equity, and inclusion) is outdated – it is missing accessibility.

Hector Ramirez stated having a hostile environment and having power differentials from the people that sit at the table and the way they respond to interested parties who ask for basic things required by federal law that have been established for 30 years are cultural things. It is seen that individuals with disabilities, particularly individuals of color,

experience significant access issues not only for services but even when trying to advocate. The speaker stated they will leave this meeting again feeling the mental health trauma as a person of color having someone who is not a person of color directing how they should talk, what they should say, and the silence in the room as it happens. Equity is a word that must be used when individuals cannot or are not allowed to talk about racism. There is racism in mental health, even in this room. It is important to call it out. The speaker stated it is what drives the speaker's community and peers with mental health conditions. People with mental illness do not drink and do drugs because they have a mental illness; it is because of how they are treated. People with mental health conditions do not end up in jails or homeless because they have a mental illness but because of how they are treated.

Hector Ramirez stated they are wearing a United Farm Workers (UFW) shirt to represent their community because, when the MHSA was passed, the UFW was the group that activated, but they are not in Sacramento so they did not get a seat at the table. Also, peer certification happened not because of what peer organizations in San Francisco were doing, but because the UFW realized peer certification was important. Despite this, they were not even included.

Hector Ramirez stated the work of the Commission has to be advanced and is very important and should be a priority, but, at the end of the day, the work that happens in this Commission and the lack of acknowledging the racism in this room is what has been oppressing individuals of color – the majority of Californians who are struggling to survive, who are in prisons, who are homeless on the streets, and who are dying.

Stacie Hiramoto acknowledged Hector Ramirez for their comments and thanked them for their courage. She commended the Commission for embarking on a Racial Equity Plan. She stated she is glad the CLCC was involved, but wished that it was able to see this final plan before it was brought to the Commission.

Stacie Hiramoto stated it was not clear if the proposed plan is just the foundation because it lacked specificity and meaningful measurements. The Commission should have been doing most of the actions in the proposed plan already. The plan does not stretch the Commission in the way it could.

Stacie Hiramoto referred to the action under DEI in Commission Staffing, "partner with other state agencies, leading organizations, and others that embrace diversity, equity, and inclusion standards," and asked what is to be done with this partnership, how to know whether a state agency or leading organization has a good DEI standard and, even if they have it in writing, whether they follow these principles, and if the Commission will not partner with an agency that does not have a good DEI standard.

Stacie Hiramoto referred to the action under DEI in Commission Staffing, "measure and monitor progress in achieving diversity, equity, and inclusion standards for the Commission's workforce," and asked about current statistics on the Commission's workforce, how many individuals of color and from the LGBTQ communities are in top management, and what will be the goal. She asked if there is a designated Equity Officer who can answer questions, and if there will be an Annual Report to the Commission.

Richard Gallo stated they are skeptical of the plan and hoped the staff, especially leadership staff, will actually follow through on this. Programs and services that serve the mentally ill population should have been provided all along. The speaker stated they did not believe that counties will embrace the Racial Equity Declaration because of bias and county politics. Counties do not want open communication with the mental health community; they want to operate the old way before the MHSA. Counties do not like the community planning process. It is important to follow the intent of the MHSA within the Commission and its partners.

Ms. Quintero thanked the public commenters for their important input and feedback. This is a work in progress.

9: <u>Innovation Implementation Plan</u> (Action)

Presenter:

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

Chair Madrigal-Weiss stated the Commission contracted with a non-profit consultant, Social Finance, to better understand the challenges that counties face in developing transformative innovations and to recommend ways to help overcome these challenges. In April of 2022, the Subcommittee on Innovation supported a package of recommendations that could help counties develop transformative innovation projects, refine the Commission's review process, and increase the dissemination of learnings. She noted that the Innovation Action Plan, PowerPoint, and all associated documents summarizing the recommendations were included in the meeting materials.

Chair Madrigal-Weiss stated the Commission will hear a presentation from staff on the strengths and challenges that counties face in developing transformative innovation and explore concerns and opportunities but will be unable to vote on this item due to the lack of a quorum. She asked staff to present this agenda item

Sharmil Shah, Psy.D., Chief, Program Operations, provided an overview, with a slide presentation, of the background, Social Finance: Systems Analysis Project, concerns and areas of opportunity, and the Innovation Implementation Plan. She stated Social Finance, in partnership with counties, Commission staff, and community organizations, have prepared drafts of several action items and, based on direction from the Subcommittee on Innovation in April of 2022, Commission staff have begun preparations to implement.

Chair Madrigal-Weiss asked Commissioner Danovitch, Vice Chair of the Subcommittee on Innovation, to say a few words on this work.

Commissioner Danovitch stated the goals of the innovation mechanism would seem to be easy to accomplish. They identify problems, develop novel solutions, implement the solutions, evaluate the effectiveness of those solutions, and disseminate or share information about them so others can replicate the success. Although this sounds straightforward, it is not. Every step is difficult to do. The mental health system of care was designed to be reliable but not innovative and novel. The challenge of taking the advantage of the opportunity to support innovative plans has been difficult.

Commissioner Danovitch encouraged everyone to read the report, including the recommendations that are understandable, coherent, feasible, practical, and should help improve the Commission's processes.

Commissioner Comments & Questions

Commissioner Brown commended Commissioners Danovitch and Boyd, Dr. Shah, and staff who worked on this in conjunction with Social Finance. The end product is an excellent example of taking a complex issue, boiling it down, and presenting it in such a way in this matrix that it is simple to understand and is not intimidating.

Public Comment

Hector Ramirez, Cal Voices ACCESS Ambassador, consumer, Los Angeles Department of Mental Health, stated they have followed this part of the MHSA and have seen how it has been bleeding taxpayers' money. It was supposed to provide innovation funding for communities, particularly those that are most impacted, disenfranchised, and marginalized. These are key words for people of color. This is an area where the MHSA, because of the lack of oversight and how these programs were being implemented, has led to counties utilizing this as an ATM for funding organizations or programs that for the most part have not benefited the community. Because of the lack of oversight and accountability, Los Angeles County in particular needs to be audited. Los Angeles County has the largest population of individuals with mental health conditions in the world and yet accessing some of these programs and being able to engage and provide feedback is impossible. The speaker stated they love what CalMHSA has done, but programs have replaced authentic interest person communities. The word "stakeholder" has been used to silence the people that need help.

Hector Ramirez stated marginalized communities such as the LGBTQ community must get funding from sources such as the tobacco industry because there is limited or no funding from this Commission to focus on the work that needs to be done. Tribal and Latino/Hispanic communities have to fundraise to provide basic services. Counties are failing communities, particularly around interested party involvement.

Hector Ramirez stated the Americans with Disabilities Act (ADA), which was codified 30 years ago, made accessibility a requirement. It is not something for the Commission to learn about and to try to do better; the Commission should have done better long ago for communities. Advocates have been asking over and over for materials to be made available in other languages for accessibility. The lack of accessibility highlights one of the major problems with this Commission. The speaker stated the hope that the Commission will learn the difference between listening and hearing. Although Commissioners are listening to public comment, they are not hearing the communities.

Richard Gallo asked if Social Finance interviewed peers as part of this project. Peers need to be included in every innovative planning process. Peers need to be a part of the team. This is missing in the documentation included in the meeting materials. The speaker suggested offering stipends to peers for their feedback on whether or not a program may be successful.

Richard Gallo asked about the number of projects that have been approved since the MHSOAC began.

Dr. Shah stated, since Fiscal Year 2015-16, the Commission has approved 187 innovation projects and authorized over $690 million in innovation work.

Richard Gallo stated Cal Voices ACCESS Ambassadors met recently to discuss the low success rate of innovation projects. The speaker stated it may be time to replace innovation projects with peer support services and programs that should have been put in place long ago to help communities in need throughout the state.

Chair Madrigal-Weiss asked if the resources specifically included for county community engagement includes peers.

Dr. Shah stated the resources are still in draft form. The plan is to include peers. Peer involvement is included in several different places such as in the draft recommended template that counties could use to submit innovation projects. She stated this project created an advisory group that included individuals with lived experience, youth, Commission staff, other members of community-based organizations, and other state agencies who were part of this work. The advisory group met several times to discuss the recommendations, challenges, and barriers. She stated Kyle Doran is on the line. She asked him to address this question.

Kyle Doran, Director of Advisory Services, Social Finance, stated, over the course of the year-long research project, Social Finance made an effort to speak to as many individuals as possible. Interviews were held with over 100 individuals including ACCESS Ambassadors and other experts with lived experience. Multiple focus groups were organized by California Mental Health Peer-Run Organizations (CAMHPRO) and the National Alliance for Mental Illness (NAMI) that met four times as part of the research project.

Stacie Hiramoto acknowledged and thanked the Commission for their efforts to improve the innovation component of the process. Approving innovation projects is one of the most important things this Commission does. Although counties do their best, innovation is the most challenging component because they are doing something that has not been done before. It is difficult to develop these projects.

Stacie Hiramoto stated communities of color and the LGBTQ, client, and consumer communities look to the innovation component as much as the prevention and early intervention (PEI) component of the MHSA for funding effective programs for individuals in their communities. This is an example of where the Commission could be more equity forward. This project was given a sole-source contract. The board and staff of Social Finance do not seem to have a lot of diversity. She asked about the basis this contract was awarded on. The contract could have gone to an organization that was led and founded by BIPOC and/or LGBTQ staff or consumer groups. This report does not touch on reducing disparities, equity, or diversity. A focus on equity and consumer empowerment should have been one of the major components of this project. The CLCC and the CFLC should have been involved with this project.

Matt Gallagher, Assistant Director, Cal Voices, thanked the Commission for discussing innovation. Since its rollout in 2012, a common theme is that innovation is

underperformed and has not lived up to its expectation or at least what the drafters of the MHSA hoped it would be. He stated the need to remember that the effectiveness of innovation starts with the Commission. He stated staff just reported on the number of innovations that have been approved by the Commission. He asked how many have not been approved or how many times Commissioners have sent an innovation plan back to the county because it was not innovative enough, it needed to be better, or it needed to have more and expect more outcomes.

Matt Gallagher stated another thing to consider is the type of oversight the Commission does after an innovation plan is approved. He asked if counties and providers come back to provide updates on their approved projects, including strategies that worked and those that did not. He stated the Helping Hand Innovation Program is documented as a failure but there was no oversight or follow-up. There was nothing done from the Commission after the Helping Hands project was approved.

Matt Gallagher suggested that the Commission consider not a support group, but a standing advisory committee on innovation and PEI, similar to the CFLC. That advisory committee should assist the Commission in updating the annual regulations for PEI and INN. Regulations should be updated every two years. This is how to foster growth.

Matt Gallagher stated the need for evaluation on this. The Commission should know the standard deviation for failed innovation projects, what works, and what does not work. The Commission should have follow-up and reporting on that so counties know what to do and what not to do. After 10 years of innovation, this information remains unknown.

Chair Madrigal-Weiss asked Executive Director Ewing to respond to Matt Gallagher's comments about following up with county innovations.

Executive Director Ewing recognized that there was a moment in time where innovation funds were flowing but investments were not being seen. Hector Ramirez referred during public comment to the work the Commission has done to publicly reveal information on the funds that counties receive, what they spend, and what they have left unspent. That information revealed the significant balances of unspent innovation funds. Since that time, the Commission has been working assertively with counties, community advocates, and others to elevate the visibility of the innovation component. Dramatic increases have been seen in interest and the number of plans coming out of the community planning process. As was presented two months ago, the Commission has been investing in strategies to strengthen the community planning process around innovation and, more broadly, the entire MHSA.

Executive Director Ewing stated what this report reflects is an evolution of that work from elevating awareness about the innovation opportunities, and that is reflected in the data that is in the dashboard, which was included in the meeting materials, that shows the number of plans that have come into the Commission and shows a high level of approval. What it does not show is the number of plans that have been withdrawn or revised as a result of the public review or Commission's review processes. This would be a much more nuanced story to tell because a number of plans come into the Commission that are subject to public review and comment and, as a result, they are either withdrawn or modified over time.

Executive Director Ewing stated, on the broader issues of how to learn from and scale effective interventions, the work done for this Innovation Implantation Plan is reflective of those challenges and the Commission's quest to understand what those opportunities are and how they might be pursued. This phase of the innovation component is a shift away from individual, one-off county innovations, although there are still many of those. There has been a shift toward multi-county collaborative learning. The example from today was the EHR project. There have been presentations on replicating the work that Solano did. 40 counties are participating in a multi-county collaborative to replicate the tremendous improvements in community engagement through the Solano County innovation that was approved five years ago. It was approved last month for other counties to replicate that.

Executive Director Ewing stated the Commission has gone from little to no attention on innovation, to greater attention on innovation, to enforcing the expenditure requirements, to counties getting engaged, and now to trying to refine and strengthen opportunities to not just do an innovation, but to evaluate, assess, and, when effective, scale. Many of the recommendations in this proposal are about taking the next step – to strengthen the evaluation and to use that information to not just support an individual county's lessons learned, but to shape understanding statewide.

Executive Director Ewing stated what the Commission is also seeing is greater awareness of opportunities to leverage the lessons learned in the mental health space to even begin to shape some of the conversations that are happening with partners through the health and human service system and even some other segments of the public sector agencies, such as in public safety and in education.

Executive Director Ewing stated this is a dynamic and iterative process. The proposal in front of the Commission is about strengthening how to learn, how to share those learnings, and how to implement those learnings beyond the individual investment of a single county.

Steve McNally suggested that presenters include links to additional information on their subject. The speaker asked the Commission to create detailed forms for presenters. It is important to include the number of individuals who come to meetings who are from the community. Also, if scaling is the goal, the speaker recommended having a provision on how the item being presented could scale. The speaker stated they will send their full written comment to staff.

Anna stated this project is a step in the right direction. The speaker echoed the comments of previous speakers, especially Stacie Hiramoto and Matt Gallagher. The speaker recommended, when approving innovation projects, encouraging counties to prioritize peer-run programs run by individuals with direct lived experience. Individuals need responsibility and independence in order to get better.

Anna recommended, while developing priorities and projects, ensuring that the voice of individuals with direct lived experience has more weight than the family member voice. Individuals with direct lived experience are the individuals receiving the services and are left out if they are not doing well. Individuals with direct lived experience need to be heard first. It is important to ensure that the community is educated and knows how to provide input and where. If there is an innovation project that will be approved in the

future or if there is research with the counties, the speaker asked to consider how the counties are helping individuals with direct lived experience get involved correctly.

10: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on November 17th in Sacramento. There being no further business, the meeting was adjourned at 12:23 p.m.

AGENDA ITEM 5

Action

November 17, 2022 Commission Meeting

Election of the Chair and Vice-Chair for 2023

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2023 will be conducted at the November 17, 2022 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and begins January 2023.

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

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
October 2022

Mayra Alvarez, Los Angeles

Current MHSOAC Vice Chair

Joined the Commission: December 2017

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

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

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

Mark Bontrager, Napa

Joined the Commission: November 2021

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

John Boyd, Psy.D, Folsom

Joined the Commission: June 2013

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

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

Sheriff Bill Brown, Lompoc

Joined the Commission: December 2010

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

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

Keyondria Bunch, Ph.D., Los Angeles

Joined the Commission: August 2017

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

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

Assemblymember Wendy Carrillo, Los Angeles

Joined the Commission: February 2018

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

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

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

Steve Carnevale, San Francisco

Joined the Commission: April 2021

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

Rayshell Chambers, Los Angeles

Joined the Commission: May 2022

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

Shuo Chen, Berkeley

Joined the Commission: April 2021

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

Senator Dave Cortese, Santa Clara

Joined the Commission: September 2021

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

Itai Danovitch, M.D., Los Angeles

Joined the Commission: February 2016

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

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

David Gordon, Sacramento

Joined the Commission: January 2013

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

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

Mara Madrigal-Weiss, San Diego

Current MHSOAC Chair

Joined the Commission: September 2017

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

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

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

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

Gladys Mitchell, Sacramento

Joined the Commission: January 2016

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

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

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

Al Rowlett, Sacramento

Joined the Commission: November 2021

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

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

Khatera Tamplen, Pleasant Hill

Joined the Commission: June 2013

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

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

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

AGENDA ITEM 7

Action

November 17, 2022 Commission Meeting

Semi-Statewide Enterprise Health Record Multi-County Innovation Project

NOTE: This item was presented at the October 27, 2022 Commission Teleconference and there are no changes. A short summary will be provided, and a motion will be presented for your consideration/vote. The materials have been provided in your packet.

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

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

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

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

The EHR Project is designed to affect local-level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting.

The overall goal to increase the quality of mental health services, including measurable outcomes and promote interagency and community collaboration. Together, these 23 counties are collectively responsible for 4,000,000 (27%) of the state's Medi-Cal beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health Services
Oversight & Accountability Commission

Commission Process for Community Engagement on Innovation Plans

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

Sharing of Innovation Projects with Community Partners

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

Semi-Statewide Electronic Health Record Project
Biography CalMHSA Presenter

Dr. Amie Miller

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

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS

SEMI-STATEWIDE ENTERPRISE HEALTH RECORD INNOVATION PROJECT

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

Review History:

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

Total: $11,310,146.54

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

Project Introduction:

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

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

Identified Need

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How this Innovation project addresses this need

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

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

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

The project identifies three key aims:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Partner Feedback

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

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

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

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

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

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

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

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

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

Learning Objectives and Evaluation:

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

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

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

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

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

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

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

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

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

The Budget

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[3] Dmh.lacounty.gov

AGENDA ITEM 8

Action

November 17, 2022 Commission Meeting

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

NOTE: This item was presented at the October 27, 2022 Commission Teleconference and there are no changes. A short summary will be provided, and a motion will be presented for your consideration/vote. The materials have been provided in your packet.

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

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

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

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

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

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

Proposed Motion: The Commission approves the Racial Equity Plan.

ELEVATING THE COMMISSION'S VOICE ON RACIAL EQUITY

Mental Health Services Oversight and Accountability Commission

Racial Equity Plan

ABOUT THE COMMISSION

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

COMMISSIONERS

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

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

ACKNOWLEDGEMENTS

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

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

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

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

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

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

INTRODUCTION

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

Disparities Persist as a Result of Structural Racism

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

Mental Health Services Act

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

Capitol Collaborative on Race and Equity

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

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

Statewide Efforts on Racial Equity

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

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

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

TRANSFORMATIONAL CHANGE IN MENTAL HEALTH

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

MISSION STATEMENT

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

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

RACIAL EQUITY PLAN

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

RACIAL EQUITY DECLARATION

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

PRIORITIZING EQUITY IN THE COMMISSION'S WORK

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

COMMISSION MEETINGS

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

Strategies to address equity in Commission meeting planning include:

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

Land Acknowledgements

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

DIVERSITY, EQUITY, AND INCLUSION IN COMMISSION STAFFING

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

The Commission will:

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

INCENTIVIZING RACIAL EQUITY IN GRANT FUNDING

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

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

INNOVATION

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

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

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

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

RESEARCH AND EVALUATION

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

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

POLICY RESEARCH

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

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

COMMUNICATIONS

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

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

ACCOUNTABILITY AND NEXT STEPS

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

Appendix A: CCORE Participating State Departments and Agencies

2020-2021 Learning Cohort

- Department of Aging
- Conservation Corps
- Fi$cal
- Department of Fish & Wildlife
- Department of Food & Agriculture
- Department of Forestry & Fire Protection
- Housing Finance Agency
- Mental Health Services Oversight & Accountability Commission
- Office of Planning & Research
- Public Utilities Commission
- Tahoe Conservancy
- Transportation Agency
- High Speed Rail Authority
- Highway Patrol
- Department of Motor Vehicles
- New Motor Vehicle Board
- Office of Traffic Safety
- Caltrans
- Transportation Commission
- Department of Water Resources

2018-2019 Learning and Implementation Cohorts

- California Arts Council
- California Coastal Commission
- California Department of Public Health
- California Department of Housing and Community Development
- California Department of Transportation
- California Department of Education
- California Department of Corrections and Rehabilitation
- California Department of Community Services and Development
- California Department of Social Services
- California Environmental Protection Agency
- Air Resources Board
- CalRecycle
- Department of Pesticide Regulation
- Department of Toxic Substances Control
- Office of Environmental Health Hazard Assessment
- State Water Resources Control Board
- California State Lands Commission
- California Strategic Growth Council & Governor's Office of Planning and Research

AGENDA ITEM 9

Action

November 17, 2022 Commission Meeting

Innovation Implementation Plan

NOTE: This item was presented at the October 27, 2022 Commission Teleconference and there are no changes. A short summary will be provided, and a motion will be presented for your consideration/vote. The materials have been provided in your packet.

Strengthening MHSA Innovation through a Culture of Learning and Collaboration

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

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

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

Catalyzing Transformational Change

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

Mental Health Services Oversight & Accountability Commission
Innovation Implementation Plan

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

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

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

Action:

- Develop a Frequently Asked Questions document that clarifies the innovation plan requirements in the Commission's regulations. The FAQ should be designed to reinforce the purpose and definition of innovation and inform and support innovation proposals with a higher likelihood of resulting in transformational innovations that can be scaled.
- Engage community and county partners to develop a community engagement resource to support the ability of counties to strengthen local engagement, including empowering local voices, perspectives, and alternative strategies for developing plans, such as human-centered design.
- Periodically convene counties and community partners to assess the impact of these resources, the need for refinements and/or alternative approaches.

- Expand the Commission's existing capacity to offer technical assistance and capacity building support to counties and community partners, consistent with its work on the alcove™ grant program, early psychosis, and school mental health, with a focus on Commission identified priorities that can be transformative.

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

Commissioners have expressed concern that the MHSA innovation component has not generated sufficient system-level reforms and that successful innovations are slow to scale. County leaders also have expressed frustration that it is unclear what the Commission is looking for when reviewing innovation proposals. To address those needs, Social Finance has recommended the following next steps:

Action:

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

3. **Goal: Facilitate learning across and within counties**

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

Action:

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

expand awareness of the innovation component of the MHSA and identify new partners to support its success.

Next Steps

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

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

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

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

Appendix A

Innovation Action Plan

Deliverable 4, MHSOAC Incubator Systems Analysis Project

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

PREPARED FOR:

Mental Health Services
Oversight & Accountability Commission

Table of Contents

Executive Summary

Introduction

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

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

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

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

Obstacles to Innovation

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

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

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

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

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

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

Summary of Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implementing these Recommendations

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

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

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

Next Steps for the Systems Analysis Project: Resource Library

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

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

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

[ii] CCR § 3910(d).

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

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

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

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

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

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

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

Methodology

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

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

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

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

Recommendation 1. Supplement the definition of innovation with further guidelines

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

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

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

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

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

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

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

Recommendation 2. Expand and deepen technical assistance to Counties

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

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

2a. Strengthen support functions to meet County needs

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

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

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

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

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

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

NEXT STEPS

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

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

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

[4] See Appendix 4 for full survey results.

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

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

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

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

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

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

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

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

NEXT STEPS

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

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

Recommendation 3. Further clarify expectations for Plan development

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

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

FIGURE 3. Overview of plan review tools

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

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

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

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

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

NEXT STEPS

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

FIGURE 4. New proposed structure of Recommended Template

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

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

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

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

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

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

FIGURE 5: Potential benefits and challenges of a discussion guide

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

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

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

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

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

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

NEXT STEPS

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

[10] Full survey results in Appendix 4.

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

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

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

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

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

NEXT STEPS

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

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

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

NEXT STEPS

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

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

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

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

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

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

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

NEXT STEPS

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

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

Recommendation 8. Develop additional orientation materials for new Commissioners

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

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

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

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

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

NEXT STEPS

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

[13] 9 CCR § 3200.184

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

Appendix I. Proposed Tools & Resources

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

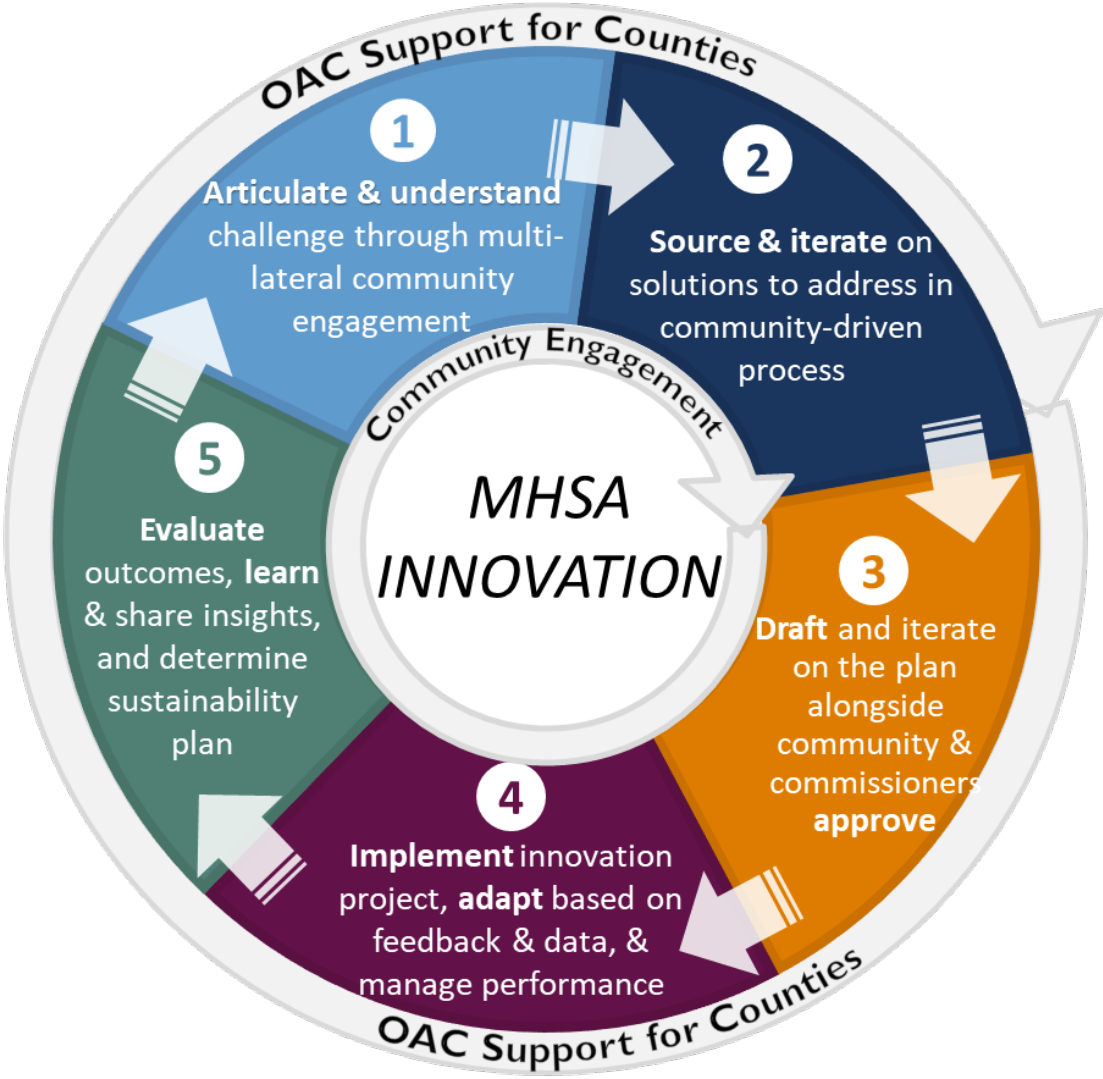
Tool Name	Description	Corresponding Recommendation in IAP
Innovation FAQ resource	Draft of resource	1a (Figure 1)
List of types of projects that would qualify as "innovative"	Draft of resource	1b (Figure 2)
Guide for working with evaluators	Draft of resource	2a
Overview of plan review tools (Recommended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

Appendix 2. Systems Analysis Project Discussion Group Participants

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

Appendix 3. Continuous Improvement Framework

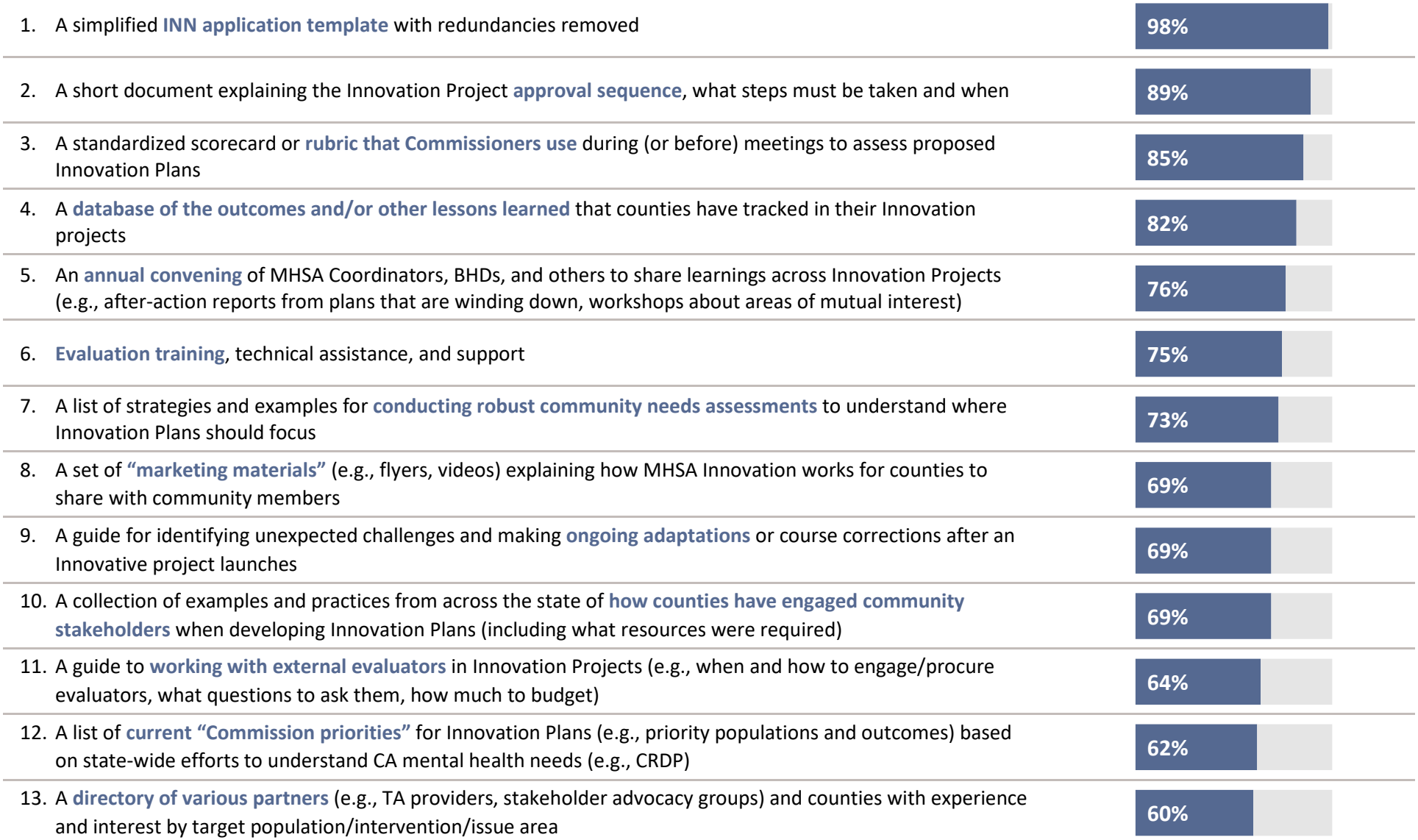
We developed this continuous improvement framework as part of this project's resource library. It is based on our review of past Innovation Plans and on our research on innovation in the public sector (see Methodology Section).



Appendix 4. MHSA Coordinator Survey Results

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

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



Appendix 5. More Suggestions from the Innovation Community

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

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

Appendix 6. Feedback from MHSOAC Committee Members

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

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

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

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

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

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

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

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

Less impact → *More impact*

●○○ → ●●●

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

Difficult to implement → *Easier to implement*

● ● ●

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

Less resources → *More resources*

$ $ $ → $ $ $

SOCIAL FINANCE

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

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

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

Less impact → *More impact*

○○○ → ●●●

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

Difficult to implement → *Easier to implement*

● ● ●

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

Less resources → *More resources*

$ $ $ → $ $ $

SOCIAL FINANCE

AGENDA ITEM 10

Action

November 17, 2022 Commission Meeting

K-12 Student Advocacy Funding Outline

Summary: The Commission will be presented with an outline for funding to support advocacy, training and education and outreach and engagement on behalf of K-12 students through the Commission's community partnership grant program.

Background: The Commission awards contracts to local and state level organizations to provide advocacy, outreach, education and training on behalf of nine specific underserved populations through a competitive Request for Proposal (RFP) processes.

In response to the Commission's request, the 2022-23 State Budget Includes $670,000 per year to support advocacy focused on the mental health needs of K-12 students. The Commission's request was made in response to historic levels of funding made available through the Mental Health Student Services Act, the Student Behavioral Health Incentive Program, and the Child and Youth Behavioral Health Initiative.

Recognizing that students are often overlooked in mental health planning discussions, K-12 student advocacy funding will provide an avenue for youth to provide input on the most pressing needs of students, help guide implementation of school-based mental health services, receive training on available supports and services, and conduct outreach and engagement to students, local-level leaders, and state-level decision makers on effective strategies to meet the mental health and wellness needs of K-12 students.

Staff proposes to use three years of funding, totaling $2,010,000, to contract with up to six organizations to provide advocacy, outreach, education and training on behalf of K-12 students. Of these six grantees, five will be local-level organizations contracted to work directly with the student populations in their respective areas. One local-level award will be provided in each of California's five regions (Superior, Bay Area, Central, Southern California, Los Angeles). The sixth award will be provided to one state-level organization to work closely with the local-level organizations to provide opportunities to increase advocacy at the state and local-level. All

advocacy contracts will be provided to organizations who have experience and capacity to work effectively with diverse student populations, and that agree to focus their efforts on addressing disparities and achieving equity.

Presenter: Tom Orrock, Chief of Community Engagement and Grants

Enclosure (1): Proposed Outline of Request for Proposal (RFP)

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

Mental Health Services
Oversight & Accountability Commission

Proposed Outline of Request for Proposal (RFP)
for the K-12 Student Advocacy Contracts
Commission Meeting – November 17, 2022

The 2022 state budget authorizes the Commission, through the annual state budget, to award $670,000 per year to one or more organizations to support mental health outreach, engagement, advocacy, education, and training on behalf of, and in collaboration with, kindergarten through 12th grade (K-12) students in California with a focus on building advocacy skills and increasing the voice of students in the planning and implementation of school-based mental health services.

Consistent with prior Commission decisions, staff is proposing to release Request for Proposals for six contracts. Five awards would be made to local-level organizations in each of California's five regions (Superior, Bay Area, Central, Southern, and Los Angeles) with experience and capacity to provide advocacy, training and education, and outreach and engagement on behalf of K-12 students. One award would be made to a state-level organization to assist students and the local-level organizations in their advocacy, training and outreach efforts to Behavioral Health Departments, school boards, County Offices of Education, youth organizations and other decision-making bodies within the region. The state-level contractor will gather information on the mental health and wellness needs of students from students and the local-level organizations and include youth voice in statewide advocacy efforts.

Total funds available for this RFP will be $2,010,000.

Interested organizations will be asked to provide state-level or local-level activities which highlight the mental health and wellness needs of students and provide opportunities for students to contribute in the mental health planning process with the goal of improving mental health outcomes for K-12 students.

Recommended Funding

Total funds available for this RFP will be $2,010,000 and the contract term will be three-years (36 months.)

Local Program Contractor Funding

The total amount available for the five (5) Local Program Contractors is $1,625,000. Each contractor would be awarded $325,000 for a three-year term.

State Level Advocacy Contractor Funding

The total amount available for the State-Level Advocacy Contractor is $385,000 for a three-year term.

Outline for the RFP

Local Program Contractor Responsibilities

Funding for the Local Program Contractor will support established organizations with experience and capacity to provide advocacy, training and education, and outreach and engagement in collaboration with K-12 students to expand advocacy efforts to increase access to mental health services. The Local Program Contractor will provide a plan and budget on how they will accomplish the following:

- Provide opportunities for students to conduct outreach and engagement on behalf of the K-12 student populations within their region.
- In partnership with students, provide local level advocacy to increase awareness of the mental health needs of students and expand access to mental health services.

- In collaboration with students, provide training and education to mental health service providers on strategies to increase student interest in the behavioral health professions.
- Conduct and facilitate community outreach to connect with community members, empower students, and engage partners serving K-12 students.
- Collaborate with the State-Level Advocacy Contractor to create a student coalition to train other students on advocacy strategies and techniques.

Statewide Advocacy Contractor Responsibilities

The organization will propose a plan that meets the following goals:

- In collaboration with K-12 students, conduct advocacy activities at the state level that addresses the critical mental health needs of students, with an emphasis on ethnically diverse, homeless, child welfare involved, transitioning and gender nonconforming, juvenile justice-involved, and disabled K-12 students.
- Provide training and education for mental health service providers, teachers, school administrative staff, professionals, peer workers, and others who serve K-12 students to be more aware of and to meet the needs of students more effectively, with an emphasis on reducing disparities, promoting continuing education and peer social and judicial advocacy.
- Implement statewide outreach and engagement strategies that raise awareness of the needs of students, inform K-12 students of available services and supports, and create advocacy and work opportunities to empower and elevate K-12 student voice.

The state level contractor will write and publish an annual report each year. This report will provide a narrative with qualitative and quantitative data detailing:

- Counties and communities reached during contracted activities.
- Information on the current needs of K-12 students, including unmet needs.
- Recommendations from students on policies and community interventions for transforming the mental health system to better serve K-12 students with emphasis on reducing disparities.
- Impact of recent investments in school-based mental health programs and how this funding could be used to meet the needs of students.

The state level contractor will provide a budget on how the funds will be spent as part of the plan.

Minimum Qualifications

The following minimum qualifications must be met.

All eligible bidders must:

1. Be an established organization which has been in operation for 2 years and has experience with programs and services related to the unique mental health needs of California's K-12 population.
2. State-level: Have experience and capacity to provide technical assistance and support to local community-based organizations;
   Local level: Have experience engaging students and capacity to provide advocacy, training, and outreach in collaboration with K-12 students.
3. Have experience and familiarity providing advocacy, training, and outreach in collaboration with K-12 students, with emphasis on addressing disparities, with an emphasis on ethnically diverse, homeless, child welfare involved, transitioning and gender nonconforming, juvenile justice-involved, and disabled K-12 students.
4. Be a non-profit organization, registered to do business in California.

RFP Timeline

January 3, 2023: RFP released to the public
February 17, 2023: Deadline to submit proposals
March 13, 2023: Commission issues Notice of Intent to Award

AGENDA ITEM 11

Action

November 17, 2022 Commission Meeting

The Mental Health Wellness Act & Older Adults

Summary: The Commission will hear a presentation by Susan DeMarois, Director of the California Department of Aging, on how Mental Health Wellness Act funds can support California's Master Plan for Aging

Background: The Commission's budget includes $20 million per year to support the Mental Health Wellness Act. In the first two rounds of funding (2014-2021), the Commission awarded funds to county behavioral health departments through a competitive grant process to build out crisis intervention response programs. The Mental Health Wellness Act, as initially drafted, limited the use of these funds to hiring personnel to support county crisis intervention programs.

In October of 2021, through public hearings and site visits, the Commission began to identify challenges in the use of these funds and priorities for the investment of the next round of funding. The Commission initially identified three priorities: 1) Strategies to reduce unnecessary Emergency Department utilization and hospitalizations, 2) Opportunities to support services for children ages zero to five, and 3) Programs to meet the needs of older adults.

In response to the Commission's request, staff sought statutory changes to the Mental Health Wellness Act that would allow Mental Health Wellness Act funds to be used to support crisis prevention and early intervention strategies, in addition to crisis response services. Staff also sought support to use the funds to award grants to partners in addition to county behavioral health departments, to support strategies other than supplemental staffing, to allow matching fund requirements and to allow competitive or non-competitive procurements when doing so is in the public interest. During the 2022-23 budget process, the Legislature and Governor authorized those changes to the Mental Health Wellness Act.

In September 2022 the Commission approved a $20 million allocation from Budget Year 2020/2021 to expand the number of EmPATH Psychiatric Crisis Stabilization Units, provide training and technical assistance to grantees, and conduct program evaluation.

Commission staff are now focusing on opportunities to support the mental health and wellness needs of young children, peer respite, improve access to SUD services, and the needs of older adults as outlined in California's Master Plan for Aging.

To support this work, the Commission will hear from the Director of the California Department of Aging, Susan DeMarois, who will outline specific opportunities for expanding mental health services to older adults which include scaling promising programs and emerging practices, data driven policy and programs, and ongoing expert advisory to guide the Master Plan implementation efforts.

Presenter(s): Susan DeMarois, Director, California Department of Aging

Enclosure: None

Handouts (2): (1) Biographical information on Susan DeMarois; (2) A PowerPoint will be provided at the meeting.

Link: California Master Plan for Aging: https://mpa.aging.ca.gov

MISCELLANEOUS ENCLOSURES

November 17, 2022 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Tentative Upcoming MHSOAC Meetings and Events

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the October Commission Meeting

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

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Kai LeMasson

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

Total Contract Amount: $2,453,736.50

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

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

Mental Health Services
Oversight & Accountability Commission

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

Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Kai LeMasson

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

Total Contract Amount: $2,453,736.50

Total Spent: **1,858,431.78**

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

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

Mental Health Services
Oversight & Accountability Commission

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

Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Rachel Heffley

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

Total Contract Amount: $5,414,545.00

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

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

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

Mental Health Services
Oversight & Accountability Commission

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

NOVEMBER 2022

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	**TOTALS**
Number of Projects	4	14	**18**
Participating Counties (unduplicated)	4	10	**14**
Dollars Requested	$12,293,270.54	$83,727,007.00	**$96,020,277.54**

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

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023	1	1	$844,750	1

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Santa Cruz	Healing The Streets	$5,735,209	5 Years	12/9/2021	Pending
Under Review	Orange	Clinical High Risk for Psychosis in Youth	$13,000,000	5 Years	2/26/2022	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	Pending
Under Review	Alameda	Peer-led Continuum for Forensics and Reentry Services	$8,615,531	5 Years	7/25/2022	Pending
Under Review	Alameda	Alternatives to Confinement	$13,432,653	5 Years	7/25/2022	Pending
Under Review	Tuolumne	Family Ties: Youth and Family Wellness	$217,953	5 Years	8/22/2022	Pending
Under Review	Santa Barbara	Housing Retention and Benefit Acquisition	$8,076,389	5 Years	9/8/2022	Pending
Under Review	Santa Clara	TGE Center	$17,298,034	54 Months	10/4/2022	Pending
Under Review	Shasta	Hope Park (Extension)	$104,760	5 Years	6/17/2022	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

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Sonoma	Semi-Statewide Enterprise Health Record	$4,420,447.54	5 Years	9/16/2022	9/27/2022
Under Final Review	Tulare	Semi-Statewide Enterprise Health Record	$6,281,021	5 Years	9/16/2022	9/27/2022
Under Final Review	Humboldt	Semi-Statewide Enterprise Health Record	$608,678	5 Years	9/16/2022	9/27/2022
Under Final Review	Colusa	Social Determinants of Rural Mental Health (Extension)	$983,124	5 Years	8/8/2022	9/20/2022

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date
Napa	FSP Multi-County Collaborative	$844,750	10/11/2022

DHCS Status Chart of County RERs Received
November 17, 2022, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated October 3, 2022. This Status Report covers FY 2019 -2020 through FY 2020-2021, all RERs prior to these fiscal years have been submitted by all counties.

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

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

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

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
November 17, 2022, Commission Meeting

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

DHCS Status Chart of County RERs Received
November 17, 2022, Commission Meeting

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

Mental Health Services
Oversight & Accountability Commission

Tentative Upcoming MHSOAC Meetings and Events

Updated 11/10/2022

NOVEMBER 2022

- 11/17: Anti-Bullying Committee Meeting
  - 3:00PM – 5:00PM
  - Public

- 11/30: PEI Subcommittee Meeting
  - 1:00PM – 3:00PM
  - Public

DECEMBER 2022

- 12/07: MHSSA Collaboration Meeting
  - 1:00PM – 3:00PM
  - Closed

- No December Commission Meeting