MHSA STAKEHOLDER LEADERSHIP COMMITTEE MEETING
SUMMARY FOR SLC MEETING ON July 19, 2010

Agenda Item	Summary of Discussion and Actions
Announcements & MHSA Planning Updates	Ky Le provided an overview of comments received during the public posting period and May 18 MHB hearing for the FY 10-11 Annual Update covering the CSS, PEI, WET and Initial Innovation plans. In addition, he provided a summary of substantive changes the MHD made to the plans in response to those comments.
PEI Statewide Projects Supplemental Assignment	Ky Le provided an overview of the proposal to "re-assign" the County's allocation for PEI Statewide Projects ($7.7M) from the California Department of Mental Health (DMH) to the California Mental Health Services Authority (CalMHSA) – a joint powers authority – for administration of the projects. If this action is not taken, then DMH will administer the programs. Reassigning the funds to and joining CalMHSA will allow the County to more directly influence the development of the programs. During the public posting period no comments were received and the MHD will proceed with the original unchanged proposal and will request that the Board of Supervisors approve the assignment at the same time that it requests the Board to consider allowing the County to join CalMHSA. The MHD clarified that only counties can join CalMHSA. Local stakeholder could provide input by 1) attending meetings of CalMHSA, 2) submitting comments directly to CalMHSA or 3) communicating through the SLC and the MHD.
FY10-11 Annual Update	The primary purpose of the Annual Update is to allow the County to access additional MHSA funds for CSS, PEI and WET programs, but not TN, in FY11. Subsequent to the posting period for the Annual Update, the MHD updated program budgets to reflect the most current information. While no new programs were proposed, several administrative changes and funding increases required the MHD to complete exhibit Fs for CSS program C-01 and HO-01. The MHD changed the CSS HO-01 program by increasing "one-time" funding by $50K to support Destination Home and moved services not targeting homeless clients to other CSS programs. The CSS C-01 program was changed to by the redirection of $250K (out of $450K set aside for services to foster youth) to ensure that CBO's could continue to provide services to uninsured youth. In addition, increased funding for C-01 exceeded the 15% limit because additional funding for Kidscope/KidConnections is needed for FY11. The MHD staff emphasized that the key task of the SLC will be to help develop a long-term CSS plan given the projected reductions in CSS funds. CSS programs will be the most impacted of all the MHSA components affected due to expected declines in state tax revenue and because the current funding level includes significant allocations to "one-time" programs. In response to a question by a stakeholder, the MHD clarified that that prudent reserve and unexpended funds were accrued.

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Innovation Plan	An overview was provided of the substantive changes uniformly made to all Innovation plans as a result of prior comments from the: OAC, MHB May 18 public hearing, MHD staff reviews, and additional stakeholder input through public input meetings. The MHD shared plans for project implementation including staffing, evaluation, and the role of the Learning Advisory Committees. Prior to the July 19 meeting, the MHD worked with small groups of stakeholders to develop a presentation about each project and select stakeholders to present to the SLC and MHB. During the meeting, 2-4 stakeholders for each project presented about the significant substantive additions made to the plans in response to comments.

INN Comments/Responses at July 19 SLC meeting

INN Projects - General Questions

Who decided 2 yrs or 3 yrs? *Stakeholders involved in project planning gave input to the length of time planned for each project. Project duration is defined as sufficient to evaluate and determine the efficacy of a model being tested.*

When establishing a clinic location shouldn't it be necessary to be along a bus route? *The accessibility of public transportation is an important factor to be considered when in determining project location.*

Overhead costs-explain difference between what is on the INN grant proposal and what is being presented? *The INN admin budget is for 2.0 FTE to operationalize the projects in a timely manner; existing 1.0 FTE- coordinator and a significant amount for evaluation of projects.*

INN-01 Early Childhood Universal Screening

Could there be community screening to identify children not seen in the doctors' offices? *First 5 screens kids in courts, Child Welfare Dept, and Juvenile Justice system, Head Start, Early HS, planning to move to S County Health clinics and SJ health clinics, and power pre-school.*

Any privacy issues with this process? *HIPAA and other confidentiality requirements will be presented to parent before they begin screening.*

How will literacy levels, language needs, human factors related to use of technology be taken into account? *Leveraged resources from partner agencies and some degree of staffing will be directed to assisting parents/caregivers to complete screens.*

INN-02 Peer Run TAY Inn

Further clarify the budget increase. *Initially the amount of funding allocated was sufficient to augment an existing program. The current amount allocated reflects sufficient funding to create a new program without leveraged resources*

Are transportation issues being considered? *Provide bus passes, center would be located close to public transport. Youth would spread the*

word to other youth about this service.
Need to address the upheaval of recent immigrants. *Immigrant transition age youth (including those who are undocumented) are particularly high-risk and require culturally and linguistically competent responses.*
Peer volunteers – who would supervise the peer volunteers? *The peers would be paid staff, supervised by other paid staff, some of whom would not be peer partners.*
If we spend less can funds be rolled into other INN projects? *Yes.*
Is there enough staffing? Supervisors, shift supervisors and program managers- all would be paid, including the youth.
Budget narrative is a prorated budget. Summary table of budget is a full annual budget. There is sufficient staffing to procure a program with this model. With this staffing model, there are 12.2 FTE instead of the 6.0 originally planned for.
How many youth will be served? *8-10 to stay overnight. Plus drop in day time services.*

<u>INN-03 MH Disorders in Adults with Autism and Developmental Delays</u>
Will the program penetrate into ethnic communities who speak languages other than English? *While the purpose of the project is not to test whether the new approach increases access to services for underserved communities, the provider will need to provide services in a culturally competent manner for those in the program.*

<u>INN-04 Older Adults</u>
If an older adult is isolated due to prolonged illness, would they still be able to benefit from the project? *For older adults referred to the project with health, mental health or other service needs, the project has significant provision for case management, referrals, and service linkage beyond the 12 weeks in which the main program offering is delivered.*
Are there plans to outreach to non-English speaking older adults? *Yes. The project anticipates the hiring of Spanish, Vietnamese, and English-speaking staff.*
Are there 4 full time staff? *Yes*
Is isolated older adult living alone? *Older adults served by the project may be physically or emotionally isolated.*
Are you starting a new story telling program or certified in current program that exists? *The program model will modify existing best practices.*
How will you engage the family? *Family members will be actively involved in process of reminiscing.*
How was 2 years funding decided? *With 2 years, we would have 5 cycles and would have enough data to determine if the project is beneficial and effective*

Many older adults with families who are isolated experience abuse and other issues. True. The project needs to be a collaborative effort, working with EPS, law enforcement, across agencies.

INN-05 Multi-Cultural Center

There are divided ethnic communities? How will you address this? *Everyone will have to work together on a daily basis. Staff will work with ethnic groups to resolve conflicts and identify inter-ethnic strategies to address problems.*

When looking at penetration of mental health services and languages, several languages are not represented at all. Also languages not represented in ECCAC. (Indian, Farsi) *It may be necessary to direct some resources from the project to reach out to ethnic communities not represented in ECCAC groups. All cultural groups are welcomed.*

INN-06 Transitional Services to Newly Released Inmates

Will there be a volunteer or staff who accompanies newly released inmate? *Project staff will work with DOC to facilitate in-reach access for discharge planning. The faith-based groups will affirm housing, transportation, medication. A Project Coordinator will arrange for training and connectivity to existing services to ensure ongoing support.*

INN-07 Mental Health Law Enforcement Post Crisis Response

Are the police debriefed in this proposal? *Yes. Law enforcement representatives will participate on the learning advisory committee for the project, which will convene bi-monthly. However, the project staff and the Learning Advisory Committee will still need to determine the extent to which individual officers involved in the incidents will participate in de-briefings.*

INN-08 Interactive Video Scenario Training

Who will participate? *Mental health department law enforcement liaisons, consumer and family representatives, and other stakeholders will develop video scenarios.*

Will there be a facilitator with these video presentations? *The video scenarios will be incorporated into CIT training. The project will also make the interactive video scenarios available for inclusion in training offered to all law enforcement personnel and in doing so reach officers that do not receive CIT training. At CIT trainings, there will be a facilitator present through the use of existing leveraged resources. However, eventually if the scenarios are incorporated into basic law enforcement training curriculum outside of CIT, the project does not budget for facilitators.*

Debriefing of those officers who do the interventions is needed. *Although debriefing of law enforcement officers is outside of the scope of*

the project, law enforcement personnel will participate in a Learning Advisory Committee for the project. Within the LAC, there are opportunities for dialogue between representatives of various stakeholder groups.

Accountability. What will we hold the police force as a whole to? *The project is intended to achieve incremental progress with the problem of inadequate mental health training for law enforcement and associated negative outcomes that arise for consumers/family members. The project attempts to reach greater numbers of law enforcement personnel through the inclusion of video scenarios that bring the perspectives of mental health consumers and ethnic communities into existing law enforcement trainings.*

Answers to MHB Questions

The following are answers to questions submitted by the members of the Mental Health Board (MHB). The MHD's responses to these questions were distributed to participants (and posted for the public) of the July 19, 2010 Stakeholder Leadership Committee (SLC) meeting. The questions and responses were also discussed at each meeting.

Questions 1 through 4 relate to the INN Plan in general. Questions 5 through 10 applies to each individual INN project. Thus, while an introductory answer is given in this document, project-specific answers can be found in each project's "Aim Statement," Work Plan Narrative (Exhibit C) or Work Plan Description (Exhibit D). In addition, these questions will be further addressed during the stakeholder's presentations. Question 11 is in regards to the Community Services and Supports (CSS) Plan. The question is answered here and will be discussed during the July 19, 2010 SLC meeting.

1. Once the county receives these MHSA Innovation Project dollars from the State, does the MHD have jurisdiction to change the projects, or redirect the funding? Or is the funding locked into these project designs? If it can be changed how will all concerned be informed?
When INN projects are approved, the County is authorized to incur expenses against each project, and receives the total funding requested for the approved projects for a specific fiscal year. As with the CSS and Prevention and Early Intervention (PEI) components, the MHD is authorized to move funds between INN projects and to adjust services so long as the target population and the overarching goals of the project(s) are not changed and so long as the project continues to meet the State's definition of "innovation." For example, during the procurement process, one project may cost less than initially budgeted, while another project may cost more. In this instance, the MHD can alter funding allocations for each project. The MHD cannot redirect unexpended funds into a new project altogether; however, it can choose to terminate a project after consultation with stakeholders.

The nature of the INN projects and the constant evaluation and assessment necessitate some flexibility in program design. It is anticipated

that the Learning Advisory Committees will be engaged in improving/adjusting the program design throughout the life of the projects.

The MHD anticipates that reporting on the progress of each INN project quarterly to the SLC and MHB. The need for significant changes to funding could be discussed in those forums.

2. What happens to the MHSA Innovation monies if a project is not supported by the MHB? *If a project is not supported by MHB, then the MHD must decide whether or not to submit the project to the Board of Supervisors. If a County-submitted project is not approved by the State, then the funding that was allocated to that project remains at the State. All INN funds are subject to reversion if not expended within three years. Based on when the funds were made available, the published INN planning estimates (annual funding allocations) and when the INN guidelines were issued, the County must expend approximately $6.5 million by June 30, 2012. For example, if only $6.0 million are expended by June 30, 2012, then $500,000 will revert to the State for allocation to all Counties using existing distribution formulas.*

3. Does the funding of these projects include funds for location, business expenses, needed insurances, transportation, forms, advertising etc...? *The expenses for each project vary, and are based on the project's services or activities. As part of a new requirement from the OAC, the MHD has inserted a budget narrative for each of the projects including one for administration. The expense category "Operating Expenses" is very broad, and can include all of the expenses listed in the Mental Health Board's question. In addition to very specific project needs, a project's operating expenses include office supplies, office equipment, shared facility expenses, postage, etc.*

4. What structure is in place to manage, oversee and steward the projects, by the MHD? *In addition to personnel directly associated with each project (as described in the budget narratives) and existing MHD managers, the INN projects will be supported by the following.*

- *The MHD's Program Planning and Development Team, including the MHSA Project Manager and the Innovation Coordinator, is responsible for working with stakeholders and other staff to fully develop implementation plans and program designs once the projects are approved by the Board of Supervisors and the State. For both contracted and County-operated projects, the team plays a lead role in ensuring that all program issues – operational, financial, legal, clinical, evaluation, etc. – are identified and addressed. The Innovation Coordinator has primary responsibility for communicating lessons learned and reports to the State and to stakeholders, for supporting the development of the Learning Advisory Committees, for monitoring fidelity to the approved project, and for assisting the MHD incorporate lessons learned into the existing system of care. The team will also coordinate the development of new INN projects based on funding availability, system needs and stakeholder input.*

- *For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each LAC will be different, all will include consumers and/or family members, providers, system partners and MHD staff. Each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned.*

- *Throughout the process, each Learning Advisory Committee will be supported by a professional program evaluator who will be assigned to each project. This resource will need to be procured and deployed in support of each project. The evaluators will serve as an additional resource to the MHD's Decision Support team.*

- *In addition, the MHD will add 1.0 full time staff persons to both the Adult/Older Adult and the Family & Children Divisions. These two operating divisions are responsible for implementing and monitoring all program services. They assume a primary role once the services are ready to be initiated. The addition of two staff persons will ensure that the INN projects are implemented expeditiously and monitored regularly. Each "Project Coordinator" will be assigned several INN projects and will assist in supporting the Learning Advisory Committees. The MHD will reassess the permanency of these positions upon completion of the initial projects since the projects are time-limited and because funding for the INN component will fluctuate significantly over the next several fiscal years.*

5. Why do these programs qualify as innovative programs? *A project meets the OAC's guidelines for being "innovative" if it 1) introduces new mental health practices/approaches, 2) changes existing ones, or 3) introduces new applications or practices/approaches that have been successful in non-mental health contexts. How each project meets these requirements is answered in the "Contribution to Learning" section of the Work Plan Narrative (Exhibit C) and will be discussed in more detail during each project's presentation.*

6. Where will the projects be located? *Although the specific location for each project has not yet been determined, the general method for delivering the service/activity – at a central location, at clients' residences, in pediatrician's offices, etc. – is identified in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.*

7. Would the project have staff members who speak languages other than English and be culturally sensitive? *While the specific language requirements will vary by project, the MHSA General Standards require the services to be provided in a culturally competent manner. At a minimum, the MHD is responsible for ensuring that services can be provided in the threshold languages. The answer to this question for each specific project can be found in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.*

8. What outcomes measures will be used to evaluate the projects? Why can these outcomes not be identified and discussed before the start of the projects? (Each project under Project Measurements has "Data Collection and Quantitative and Qualitative analysis" but does not list what will make this up and what results would be considered a success and what would be considered a failure.) *The Work Plan Narratives have been revised to include statements that articulate each project's aim and success measures. These measures and the methods for their collection and evaluation will be finalized in conjunction with the Learning Advisory Committees prior to the initiation of services. The answer to this question for each specific project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

9. How will these projects sustain themselves after the funding ends in 2 to 3 years? *While INN funds cannot be used to sustain a project indefinitely, the Learning Advisory Committees, stakeholders and the MHB will be involved in recommending how the lessons learned from each project can be "sustained." As indicated in the "Timeline" section of each Work Plan Narrative (Exhibit C), this question will be taken up well before a project is scheduled to end. Although an obvious method would be to redirect other funds to an INN program/service, the results from an INN project could impact the system in ways that would require little or no County funding. For example, the lessons learned could convince providers to alter existing approaches or service delivery methods, change departmental policies, or access other funding sources. The methods specific for each project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

10. What product or outcome is expected by the MHD from the MHSA Innovation Projects, and how will these impact the annual plan for future years? *Each INN project is expected to contribute to learning by "providing an opportunity to try out new approaches that can inform the current and future practices/approaches in communities." The lessons learned – from successes and failures – could be used to modify current practices or replace entire programs and services. Although not the focus of the INN component, each INN project will produce tangible benefits to clients and the system in the form of services, equipment, partnerships, training, new service delivery models and*

research. The "product" for each project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation. (Please also see question #9.)

11. Are the programs implemented as approved, (9 Strategic Plans)? What Quantitative Data is available?

A) *As part of the County's FY08-09 Annual Update, the MHD consolidated the original CSS Plan's 20 work plans into nine work plans, which have mostly been implemented as approved. By implementation, the County is referring to the processes associated with the programs, services or activities (such as needs assessments) that were identified in the original plan and/or as modified and endorsed by local stakeholders. Generally speaking, FSP, other direct service and outreach programs were implemented as approved. The MHD experienced some delays associated with contractual, logistical or procurement processes inherent in starting new services in a public mental health system. Other challenges resulted from the need to forge more formal collaborations with key system partners (juvenile justice systems, foster care systems, etc.) in order to integrate services. A summary of each CSS work plan, its target population, strategies and current programs is described in the "CSS Plan Summary Documents," which has been provided as part of the SLC/MHB packet.*

There are two key differences between CSS implementation and the approved plans. First, the original CSS plan called for the development of a time-limited pilot program to address "first breaks" or the "first onset" of mental illness among transition age youth. Since the CSS plan only allocated "one-time" funds for the program, the County determined that the intended goals of the program would be better met and sustained under the PEI component (see PEI Program/Project 3). Second, while the County has implemented one centralized Mental Health Urgent Care program, the original plan called for two additional smaller sites in the northern and southern regions of the County and for mobile crisis response capabilities. Both goals remain integral to increasing residents' access to non-emergency mental health services. As MHUC operations are optimized, the County will develop appropriate implementation strategies in light of projected decreases in MHSA funds.

In addition, while the County has had success incorporating consumers and family members in direct service roles (80-90 individuals) and in system planning, staff and stakeholders acknowledge that the outcomes are far short of intentions. The County will continue efforts to develop more cohesive and robust family member-run and consumer-run programs. These efforts will be integrated with related programs under WET, PEI, INN and CFTN.

B) *Currently, quantitative data is available, but with significant limitations. First, outcome data (changes for clients) is extremely difficult to*

obtain and present systematically. With significant effort, the MHD can provide outcome data for specific programs such as the FSP-90 program operated by Momentum for Mental Health. With even greater effort the MHD can provide some outcome data for very similar programs such as all FSP programs serving TAY. However, because the MHD is still developing standardized, global performance measures, outcome data for entire systems of care (e.g. all adults) cannot be provided because of differences in service levels, need, budgets, etc. Requests for outcome data should be made for specific programs with time dedicated for in-depth presentations.

Second, while utilization data for treatment services are available, utilization data for outreach and engagement services are generally softer and more prone to error. For example, the ECCACs diligently track the services they provide, but since they must do so manually, there is often greater room for error. Similarly, there are challenges related to determining the number of unduplicated clients that CSS work plans or programs serve. Quarterly, the MHD reports on the number of clients served by each CSS work plan. However, there is often significant overlap between CSS work plans and between CSS and "non-CSS" programs. As a result the reported numbers are generally very useful for understanding the progress of specific programs, but are less useful when trying to gauge the progress of an entire work plan. For example, CSS Work Plan A-01 consists of nearly $24 million in programs and services that are both stand-alone and augmentations or expansions of existing programs.

While quantitative data is limited, it does exist, and can be utilized to develop informative reports. Both the MHD and stakeholders should continue to refine reports, improve capabilities (e.g. redeploying an Electronic Health Record), standardize performance measures, and communicate expectations and limitations in order to make the best-informed decisions as possible.

After all presentations were delivered and time provided for questions for each project, the SLC voted to approve the FY10-11 Annual Update, Supplemental Assignment of PEI funds, and all 8 Innovation plans.

Additional Comments/Responses for July 19 SLC Meeting.

Written Comment from Hope Holland after the MHB Meeting:
The Community Supports (INN) projects 1 (through) 8, and has been part of the planning process. No one in the community objects and I wish to inform the Board of Supervisors that the only objection from the community was an objection to the Mental Health Board.

Comment Received 7/20/19 (Anonymous) I am concerned about the Mental Health Department's summation of the Community Services

and Supports phase of MHSA implementation in Santa Clara County. In "Answers to Mental Health Board Questions" on page 5, the MHD states that there are two "key differences" between the CSS Plans as approved and as implemented. As an explanation of the second of these key differences the MHD provides a mere three sentences: *"In addition, while the County has had success incorporating consumers and family members in direct service roles (80-90 individuals), and in system planning, staff and stakeholders acknowledge that the outcomes are far short of intentions. The County will continue efforts to develop more cohesive and robust family member-run and consumer-run programs. These efforts will be integrated with related programs in WET, PEI , INN , and CFTN."*

This brief paragraph is deeply disappointing to me, as a family member, a member of the community, and a County employee. The involvement of family members and consumers in the planning and delivery of services, and in the transformation of the system, was a key goal of the Mental Health Services Act. For the County MHD to say only, that outcomes fell short of intentions, gives short shrift to this key component of the CSS plans, and it gives no explanation, and holds no one accountable, for this implementation failure. Further, the one success that is touted, the incorporation of consumers and family members in direct service roles, is misleading when in reality virtually all of these 80-90 individuals are employed in non-permanent, non-benefited, part-time, contracted positions, which have not been fully integrated into County-operated programs, and two of the permanent positions the MHD created for program managers to lead this effort have been eliminated. Finally, the statement that the Department will continue efforts to develop family member-run and consumer-run programs is rendered meaningless by the absence of any mention of the commitment of funds, or identification of individuals in the administration who will be responsible and accountable for these efforts.

As the stakeholders consider plans for future components of the Mental Health Services Act, it is important to keep in mind the Department's track record with the implementation of previous components of the CSS plans, and, in light of this track record, it is important for the Mental Health Board to continue to provide appropriate oversight and accountability with respect to the County's use of MHSA funds.

MHD Response: *The MHD continues to pursue the development of a multi-level mental health peer partner classification. The classification is under review by County human resources. Excluding consumer and family positions that are funded as part of contracted services, the CSS plan includes over $1.7M for consumer and family member positions. Under PEI, approximately $1 million are set aside for consumer and family member positions. Finally, under the WET component, approximately $450,000 are set aside to help recruit, train and incorporate consumer and family members into direct service roles. Peer and Family Partners will have significant paid roles in the implementation several of the County's TN projects. Under INN, peers and family members play significant roles in Project 2, 5, 7 and 8.*

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