

MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
September 27-28, 2012

September 27th Location:
Loma Linda University
Behavioral Health Institute
1686 Barton Road
Redlands, California 92373

September 28th Location:
The Mission Inn
Spanish Art Gallery
3649 Mission Inn Avenue
Riverside, California 92501
866-817-6550; Code 3190377

1. Call to Order

Chair Poaster called the September 27th meeting to order at 9:03 a.m.

2. Roll Call

Commissioners in attendance: Larry Poaster, Chair; Richard Van Horn, Vice Chair; Bill Brown, Victor Carrion, Ralph Nelson, Jr., David Pating, Andrew Poat, and Tina Wooton.

Not in attendance: Senator Lou Correa, Assembly Member Mary Hayashi, and Eduardo Vega.

A quorum was established.

3. Adopt Minutes of the July 26, 2012, MHSOAC Meeting
MHSOAC Calendar, September – November 2012
MHSOAC Dashboard, August 2012 and September 2012

Commissioner Poat stated that he would submit clarification of some of his comments at a later time, to be added to the final copy of the minutes.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Nelson, the Commission voted unanimously to adopt the minutes of the July 26, 2012, MHSOAC Meeting as to be amended by Commissioner Poat's clarifications*

4. Welcome by Loma Linda University Behavioral Health Institute

Ronald Carter, Ph.D. Provost of Loma Linda University, welcomed the Commission to the Loma Linda University, Behavioral Health Institute (BHI). He gave an overview

of the many programs available that emphasize whole health and respect for individuals and recovery.

Beverly Buckles, DSW, Dean of the Loma Linda School of Behavioral Health, stated that the BHI Mission Statement is realized through integrated service, education, and research in pursuit of whole-person care. The BHI has been addressing poorly-coordinated behavioral health service issues across the campus. Through the insight of BHI's last two presidents and the change in health care, BHI is positioned to move toward integration of behavioral health into primary care. BHI creates a milieu for interdisciplinary coordination, involving both faculty and students, dedicated to recovery-oriented services that provide an innovative, whole-life experience for the citizens of California.

Commissioner Pating suggested offering an opportunity for Loma Linda trainees to work with the Commission to gain policy experience at the state level. Dr. Buckles stated that BHI students travel to Sacramento every year; policy students could extend that stay for this opportunity.

5. Elect Chair-Vice Chair for 2013

Filomena Yeroshek, MHSOAC Chief Counsel, asked for nominations for chair for the Commission for 2013.

***Motion:** Upon motion by Commissioner Brown, seconded by Commissioner Poat, the Commission voted unanimously to elect Richard Van Horn as chair of MHSOAC for 2013.*

Chief Counsel Yeroshek asked for nominations for vice chair for the Commission for 2013.

***Motion:** Upon motion by Chair Poaster, seconded by Commissioner Poat, the Commission voted unanimously to elect David Pating as vice-chair of MHSOAC for 2013.*

6. Consider Recommendation to Approve Contract with Mental Health Association of California on Behalf of the California Youth Empowerment Network (CAYEN)

Vice-chair Van Horn recused himself from the discussion and removed himself from his seat during the contract discussion.

Aaron Carruthers, MHSOAC Chief Deputy Executive Director, stated that the purpose of the presentation is to review a draft Scope of Work for a contract with the Mental Health Association in California (MHAC) on behalf of CAYEN and to consider a proposed motion to execute that contract.

The purpose of the CAYEN contract is to support transitional age youth (TAY) advocacy efforts in the mental health system, in order to ensure that counties include TAY in community planning for mental health services, and to see that services identified by young people as effective are put into practice.

The Senate budget subcommittee acted to reinstate a contract which used to be with the Department of Mental Health for Fiscal Year (FY) 2012-2013 for \$300,000 with MHSOAC. There are ten proposed deliverables for this contract.

- Expand outreach to TAY by developing a strategic plan that will provide the youth perspective on mental health issues. This outreach is to be accomplished with surveys and reports to MHSOAC.
- Maintain a website that provides a user-friendly repository of mental health information, which will include resources of relevance for TAY related to mental health, legislation, and policy issues; and information on how youth can become involved in their local mental health planning processes.
- Extend the advocacy network by developing a directory of drop-in centers specifically serving TAY across the state, conducting quarterly forums with drop-in centers serving TAY, and providing forum reports to MHSOAC.
- Support the CAYEN board through mentoring and leadership development by recommending, educating, and supporting board members to apply for committees, boards, and advisory councils within the Mental Health Services Act (MHSA) at state and local levels.
- Develop curriculum for training designed to educate TAY on methods and effective strategies of self advocacy regarding mental health issues in their communities. This is to be taught in local communities at youth service provider agencies.
- Promote attendance at Art with Impact events to raise awareness and reduce stigma associated with mental health.
- Support, organize, and staff the CAYEN board annual strategic planning meeting, which focuses on training, networking, strategic planning, priorities and decision making, and educating TAY on mental health policy issues.
- Conduct two skill-building seminars each year for CAYEN members on advocacy, leadership, and other topics identified by the CAYEN board.
- Support the attendance of board members at up to four conferences each year which will enable staff to increase exposure to, and familiarity with, mental health issues and provide networking opportunities for TAY.
- Present to statewide and local policy makers the TAY perspective on mental health policy issues. This will include providing consultation to MHSOAC, the California Mental Health Directors Association (CMHDA), the Department of Health Care Services (DHCS), the Office of Statewide Health Planning and Development (OSHPD), and other relevant stakeholders.

Commissioner Questions

Commissioner Carrion asked if CAYEN services are only for TAY. Chief Deputy Executive Director Carruthers answered that CAYEN is an advocacy network on behalf of TAY ages 16 to 25, rather than a direct service provider.

Commissioner Poat questioned why the contract was not announced for competition and stated that his understanding was its administration had been distributed by the Legislature. Chief Deputy Executive Director Carruthers clarified that the Health and Human Services sub three committee specifically granted \$300,000 to MHSOAC for CAYEN. By implementing the Senate's decision, the deliverables will be strengthened to better serve the MHSOAC.

Commissioner Pating asked if he could have a summary of the preexisting contract formally under the Department of Mental Health (DMH), and if MHAC administering the contract is a pass-through because CAYEN is a subsidiary. He also inquired as to what the mechanism for supervising the deliverables would be and if MHSOAC actually has the capacity to perform that function. Chief Deputy Executive Director Carruthers answered that the administrative and programmatic staff at MHSOAC are very capable in monitoring the contract. He added that the previous contract was inadvertently eliminated. In order to ensure that the contract was replaced, the Senate provided general guidance regarding county inclusion of TAY in mental health community planning, implementation of services that TAY have identified as effective, and incorporation of TAY perspective in county planning processes.

Commissioner Poat asked if there was a protocol for the contract. Chief Deputy Executive Director Carruthers responded affirmatively and added that staff will manage and monitor the deliverables to ensure they are completed on time. Commissioner Pating added that CAYEN members' participation on MHSOAC Services Committees has been a valuable contribution.

Commissioner Brown asked whether a vetting process exists for the identification of effective services. Chief Deputy Executive Director Carruthers responded that the identification of effective services was part of the Senate's direction. Commissioners Brown and Poat agreed that the language regarding a formal evaluation mechanism is unclear, and requested further information in the future.

Commissioner Nelson inquired as to whether the Commission would be receiving a timeframe for expected deliverables and if regular reports on the progress would be made. Chair Poaster answered that the Commission will develop a system for timelines on the deliverables in the future. Executive Director Gauger added that there are timeframes and specific dates by which the deliverables are due and further stated that staff will monitor the progress of the deliverables in addition to reviewing them so as to ensure that contract requirements are met before reimbursement.

Commissioner Poat suggested that staff provide a scheduled contract management report summarizing the progress contracts have made in alignment with the

Commission's standards, as well as an implementation report, and a reporting schedule. He offered to assist in structuring this process.

Executive Director Gauger reiterated that provisions have been built into the contract requiring CAYEN to make progress reports to the Commissioners at specific intervals throughout the length of the contract.

Commissioner Poat opined that the report should be handled at the staff level because Commissioners do not have enough time to hear about every deliverable made. He reaffirmed that he would like to have a process in place and a set of standards to be met for staff contract management and monitoring.

Commissioner Pating recommended discussing this further in Services Committee to which Commissioner Poat agreed.

Commissioner Carrion asked if there was a little bit of background regarding why the Senate took this measure. Chief Deputy Executive Director Carruthers answered that DMH previously had a contract with CAYEN that was miscategorized when the state brought down the cap on the spending of administrative funds from 5% to 3.5%. As a result of the miscategorization, that contract was erroneously eliminated. The Senate took particular interest in making sure the work in the contract continued and so took the action in an attempt to remedy the mistake.

Public Comment

Amber Burkan, the Director of Special Programs of the CAYEN, assured Commissioners that MHSOAC staff have been spectacular in working with CAYEN in the development of the deliverables in the contract, which include reports, and checks and balances. MHSOAC staff will review drafts of the reports before they are issued to Commissioners.

Kathleen Derby, MHSA Policy Coordinator of the National Alliance on Mental Illness (NAMI) California, asserted that NAMI California supports CAYEN's efforts to involve TAY consumers and incorporate their insights in the service evaluation process, and looks forward to future collaboration with CAYEN. She added that the word "TAY" is, in her opinion, putting an acronym on a group of people and suggested that should be considered in the future.

Commissioner Discussion

Chair Poaster stressed the importance of the CAYEN contract and the deliverables it is set to produce. He wanted to make it known that staff has taken very seriously its emerging responsibility of managing contracts and he invited Commissioners to take a look at the final CAYEN contract and compare it to the contract that previously existed. He added that the Commission is very aware of the public commentary that is currently being made and asseverated that some statements in the press have been unfortunately noxious. While differences in opinion are welcomed and appreciated, he wanted it known that he and Chair-Elect Van Horn have worked very hard with staff to ensure that the importance of these contracts is understood. He added that the state auditor will be looking very carefully at these contracts as part of

the audit that the legislature asked for and that the Commission is very cognizant of that.

Commissioner Poat emphasized the importance and challenge of designing protocols and providing adequate notice in a public process. He cautioned, as public funds are not ordinarily used in a policy process of this kind, against working outside of the public interest goals established in Proposition 63. He recommended using the Public Utilities Commission Office of Public Interest as a model, and suggested incorporating a contract status update into the next MHSOAC Work Plan.

Commissioner Brown asked for clarification regarding the services that TAY say are working- does this pertain to new or existing services. Chair Poaster answered that TAY involvement in service evaluation is an inclusionary process, incorporating their feedback on existing services.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Poat, the Commission voted unanimously to authorize the Executive Director to execute the contract with the Mental Health Association in California on behalf of the California Youth Empowerment Network for three years for \$300,000 per year for the deliverables outlined by staff.*

Commissioner Pating questioned Executive Director Gauger about the status of the contracts that were under DMH for the perspective older adults. MHSOAC had been building strategic linkages with diverse groups, which were instrumental in integrating access efforts at the state and county levels. With the elimination of DMH, it has been difficult to find the same level of vested interest. He asked whether DHCS will renew those contracts.

Executive Director Gauger responded that the contract has been terminated. She and Chair Poaster agreed that, due to the reduction of the administrative fund through Assembly Bill (AB) 100, any contract renewal must be discussed during the budget change proposal process.

7. Review and Approve Proposed Outline for Client Stakeholder Contract Request for Proposal (RFP)

Chief Deputy Executive Director Carruthers declared that the purpose of the presentation is to review and approve an outline of a Scope of Work for a client stakeholder contract which will be released as a request for proposal (RFP).

In response to the FY 2012-2013 state budget, contracts, services, and budgetary authority were redistributed. MHSOAC received funding and authority to award a client stakeholder contract.

The Commission is statutorily required to ensure that the perspective and participation of consumers and family members influence its decisions, and to utilize administrative funds to assist consumers and family members in receiving quality, accessible services from state and county agencies. MHSA has been amended, under Senate Bill (SB) 1467 to strengthen the counties' partnerships with

constituents and stakeholders, including stakeholder involvement in important processes, such as policy. This contract can be an opportunity to support those efforts in the community.

The overall principles of what this contract would embody are:

- The contract should be deliverables-based.
- Deliverables should be tied to MHSA and the values and logic model of MHSOAC.
- Deliverables should predominately affect the mental health system as a whole.
- The contract should provide for consumer outreach and support, in order for consumer perspective to be a significant factor in the MHSOAC's decisions and to foster a robust local stakeholder process.

In addition to the overall principles, there are specific recommended deliverables within the Scope of Work:

- Deliverable 1: An assessment of the local stakeholder process, regarding Welfare and Institutions Code (WIC) 5848(a).
- Deliverable 2: A report of findings of that assessment to the Commission, including a narrative and matrices regarding individual counties' practices, policies, and processes to identify similarities and best practices.
- Deliverable 3: Development of curriculum and training to improve stakeholder involvement as assessed in the previous deliverables.
- Deliverable 4: Establishment of an expert pool to assemble, train, and maintain an expert pool of consumers whose subject matter expertise and perspective can be utilized by the MHSOAC.
- Deliverable 5: Staffing meetings to provide consumer perspective at state and local levels, as well as at MHSOAC meetings.

Commission staff recommends the following minimum qualifications for a successful bidder:

- Have evidence of capacity to provide statewide, county-level, and state-level participation
- Be a non-profit organization
- Have a governing board that is at least 51% mental health consumers
- Have evidence of capacity to engage diverse communities reflective of the California population that have been unserved, underserved, or inappropriately served in the mental health system

Commissioner Questions

Commissioner Poat requested clarification regarding the requirement for 51% consumer participation on the board of qualifying applicants. Chief Deputy Executive Director Carruthers clarified that this board will evaluate consumers' perceptions of the process and suggestions for improvement. Chair Poaster asked that the rest of this particular conversation be discussed after public comment.

Commissioner Pating asked if client participation was specifically mandated, and if that will exclude important non-consumer stakeholder participation. Chief Deputy Executive Director Carruthers answered that this comes from the Budget Act of 2012.

Commissioner Nelson recommended requiring applicants for contracts to have a fiscal agent. Chief Deputy Executive Director Carruthers divulged that it is not one of the stated qualifications, though it could be if the Commission wished. Chair Poaster suggested the Commission discuss incorporating this into the minimum qualifications after public comment.

Public Comment

Steve Leoni, of MHAC, asked that the Commission consider the Network when making major decisions, as it plays a crucial part in the national discussion about recovery. Whoever gets the contract needs to have a connection with the national conversation. He suggested requiring 75%, instead of 51%, consumer members on boards of applicants.

Ms. Derby agreed that the minimum percentage of consumers on applicants' board should be higher. She pointed out that the process of responding to an RFP limits any future development the applicant may wish to engage in, which goes against WIC 5848(a), and recommended providing for this in the proposed Scope of Work. She also cautioned that consumers may be reluctant to participate out of fear of retaliation within the community.

Gregory Wright, who is on the Orange County Mental Health Board and the Arts for Wellness Committee, put forward that while Orange County has active stakeholder participation, other counties experience such a disconnect that their mental health departments refuse to listen to the community or mental health boards. He recommended including language in the contract to require that mental health departments train and work with clients.

Commissioner Discussion

Chair Poaster declared for the record that Commissioner Vega recused himself from participating in discussions of this issue because of potential conflict of interest.

Chair Poaster began discussion of three issues raised during the question period: 1) what the intent behind the word "assessment" is in the community planning process, 2) how community review processes will be coordinated, and 3) how to ensure meaningful stakeholder involvement in light of the policy shifts in AB 100.

Commissioner Poat opined that the Commission, during this innovative process, needs to have clearly-defined goals to be achieved through a contract before offering it to applicants. For example, the consumer engagement process should consist of outreach, group facilitation, priority setting, recommendation, implementation, and reports to stakeholders.

Commissioner Pating commended Chief Deputy Executive Director Carruthers expressing that he captured the overall principles of the stakeholder contract clearly. It can be difficult to define a “robust” stakeholder process; Ann Collentine’s model includes evaluating attendees’ levels of participation, joint decision-making, and so on, which, combined with the principles in the presentation, can foster stakeholder representation in contracts. Commissioner Pating concurred with Commissioner Poat in that the Commission needs to develop a clear vision.

Vice Chair Van Horn stated that the development of consumer involvement is widely varied around the state, and questioned what the deliverables were in the DMH contract. He agreed that the available fund is too low and suggested an organization with a fiscal agent for support.

Commissioner Pating suggested creating a policy summary, combining the different types of evaluation, and focusing funding on consumer support and development. Commissioner Nelson postulated that this may be an opportunity to discuss basic stakeholder capacities and develop the system.

Commissioner Poat asked what model the contract is pursuing. If this is a contract then need to speak more to the capacity to develop boards and independent funding sources. Regardless if this is a continuing part of Prop 63 expenditures or capacity building, a more robust discussion is going to be needed in order to determine what the legislature actually wanted when the contract was handed off to the Commission. Executive Director Gauger answered that it will incorporate some of the requirements of the MHSA, to follow the Commission's role as defined by law in lieu of more specific direction.

Commissioner Poat suggested asking consumer groups if they feel this is sustainable or a continuing program. Commissioner Pating added that the stakeholder process must be strong, as well as the stakeholder groups themselves; Commissioner Poat agreed that each county needs to sustain its own stakeholder process to contribute to statewide capacity. Chair Poaster reminded Commissioner Poat that a dynamic discussion such as this could be applied to all of the other contracts and that it would be unfair to single out the client stakeholder group. He expressed that the vision of capacity building as pointed out by Commissioner Poat is difficult to envision and voiced his doubt that it even works. He clarified that what Staff was trying to do is base these deliverables on what the three or four statutory requirements are.

Commissioner Brown questioned whether the 51% consumer requirement for the governing board of applicants will greatly limit the number of applicants that meet the other qualifications. Vice Chair Van Horn responded that, while other contracts

require 51% consumers and family, this requirement for direct consumers was taken from the Substance Abuse and Mental Health Services Administration (SAMHSA). Commissioner Brown advised balancing consumer presence on the board with a record of successful stakeholder advocacy. Commissioner Nelson recommended coordinating the differing perspectives of consumers, families of adults, and families of minors to develop a local stakeholder process for all contracts.

Commissioner Carrion surmised that it seems the Commission needs two RFPs, one for stakeholder advocacy and one to oversee stakeholder process. Chair Poaster agreed, but added that work will be done on the deliverables regarding stakeholder contracts, with a more formal evaluation of community planning process later.

Chief Deputy Executive Director Carruthers suggested language for a proposed revision, changing “assessment” to “inventory” in Deliverable 1, and then to ask the winning agency of this RFP to work with other stakeholder contracts to perform this inventory and then combine the findings into one report which would then be used to inform the evaluation efforts. The “inventory” would examine the local community planning process and determine, for example, if the county has codified their stakeholder process, what are the elements of individual county stakeholder processes, are the stakeholder process groups different for annual updates versus new plans, etc. In other words, an inventory of counties’ implementation of WIC 5848(a) would be taken.

Public Comment

Ms. Derby informed the Commission that according to WIC 5848(a), stakeholder engagement processes should be considered in addition to community planning processes. Ms. Burkan replied that CAYEN would participate in this if it were included in its funding or deliverable. Executive Director Gauger agreed that, if this is something CAYEN wants to pursue, it will need to be exchanged for a different deliverable to stay within the budget.

Jane Adcock, Executive Officer of the California Mental Health Planning Council (CMHPC), stated that the California Stakeholder Process Coalition (CSPC) has been working with Senator Steinberg’s office to develop both policy and language to define a meaningful stakeholder involvement, which they will request DHCS include in county performance contracts. They are actively working with a group of stakeholders from around the state and with CMHDA to define stakeholder process. Ms. Adcock invited MHSOAC to work with CSPC.

Executive Director Gauger stated that both she and Chief Deputy Executive Director Carruthers have been participating in that coalition and will provide the Commission with a final document.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Poat, the Commission voted unanimously to approve the Draft Outline for Request for Proposals for Client Stakeholder Contract that develops a curriculum and provides training to clients to ensure*

meaningful stakeholder involvement on local mental health policy, program planning and implementation, monitoring quality improvement, evaluation and budget allocations; assembles, trains, and maintains an expert pool of clients whose subject matter expertise and perspective can be utilized by the MHSOAC; provides at the state and local levels, as well as at MHSOAC-specific meetings, the perspective of clients and other individuals with lived experiences across the lifespan, including individuals from unserved, underserved, and inappropriately-served communities; conducts a survey or inventory of local stakeholder involvement and community planning processes that is developed in collaboration with other MHSOAC stakeholder contract recipients; and provides the MHSOAC a unified report on the results that may be used for evaluation purposes.

8. General Public Comment

No public comment.

9. Evaluation Committee

Recommendations for Use of \$875,000 in FY 2012-2013 Funds for Evaluation

Before the presentation, Chair Poaster read this statement for the record: “In the spirit of transparency, I want to state on the record that there are some Commissioners who are also board members of nonprofit organizations that may or may not have any interest in possibly bidding on any of the evaluation projects discussed today. There is no conflict of interest in today’s decision because it is merely a determination of what general evaluation projects will be funded. There is no discussion nor decision as to what organizations will be funded. That decision will be made in several months after the results of a competitive RFP process is used. At that time, any possible conflict of interest will be revisited.”

Vice Chair Van Horn stated that the Evaluation Committee has identified proposals for the Commission to fund in FY 2012/2013 .

Presentation

Renay Bradley, Ph.D., MHSOAC Chief of Research and Evaluation, reported that the Commission will consider eleven proposals provided by the Evaluation Committee and staff regarding priorities for use of the \$875,000 evaluation funding for FY 2012-2013. A group of the proposals were posed by Dr. Meisel, based on her thoughts about what to include in the Master Plan. Dr. Bradley went on to present four of those eleven proposals.

Proposal J is the evaluation of the impact of the community planning process through participatory research. Results will be used to develop criteria for effective community planning that can then be used for continuous quality improvement.

Proposal M is the collection of baseline priority indicator data regarding individual- and system-level outcomes, focusing on comparing current data and data prior to the implementation of MHSA.

Proposal E is an assessment and improvement of Innovation (INN) program evaluations. INN programs enable counties to test new methods before integrating them into current services. Proposal E will allow MHSOAC to survey current evaluation methods to create a process to ensure that those evaluations will improve county ability to incorporate innovative methods.

Proposal Z is providing resources for the strengthening of data collection systems and standardized reporting within the Community Services and Support (CSS) component.

Dr. Bradley noted that in two of the proposals, the monetary ranges start at zero dollars. The reason for this is because MHSOAC staff has identified different ways to follow through with these evaluation ideas. For example, there might be overlap with the Community Planning process and Client Stakeholder contract.

Commissioner Questions

Commissioner Carrion observed that eleven proposals were presented; some were taken off the table, and some were integrated. He took notice of the ideas surrounding evaluating INN and participation and inquired as to whether a proposal existed that would study already implemented programs currently lacking data showing whether they work or not.

Dr. Bradley replied that the University of California, Los Angeles (UCLA) is presently looking at Full Service Partnerships and the clients that go through them and are trying to establish trends for fiscal years starting with FY 2008-2009 and FY 2009-2010. She added that Carol Hood would be providing a brief overview of the evaluations currently being conducted at the next day's meeting, but cautioned that, while evaluations of programs like those have begun, there is still a long way to go before any results are seen.

Commissioner Nelson asked what the indicators were for FY 2004-2005. Dr. Bradley answered that a detailed presentation would address those indicators at the next day's meeting.

Commissioner Poat asked Dr. Bradley to characterize "participatory research". Dr. Bradley defined it as the engagement of the subjects of research in the research process. Commissioner Van Horn supplemented the explanation by giving a brief overview of how participatory research came about and related it to stakeholder involvement.

Commissioner Pating affirmed that participatory research is a very valid method for obtaining valuable, compelling data and added that these proposals are only the first attempts to identify large areas of interest in INN and community planning.

Commissioner Carrion supplemented the discussion with his understanding of the proposals in that the committee is proposing areas that need further study. Only when these proposals are approved by the Commission will the study methods solidify.

Dr. Bradley provided some examples of questions that could be asked in these evaluations: How can we measure the advocacy of the planning process? What factors make it a strong process? Are any facets of that process impacting outcomes related to MHSA?

Commissioner Nelson voiced his concern that some populations such as the homeless and incarcerated will not be included in the evaluations simply because the counties don't make the effort to do so for the researchers. He cited the last study that UCLA presented to the Commission stating that when he brought up this issue previously, he was informed that it is the county's job to provide the subjects. He asked if MHSOAC staff has devised a process that will ensure a wide range of stakeholders are utilized and added that while some populations may be more compliant than others, that in no way means the others should not be included in the studies.

Chair Poaster conveyed to the Commission his understanding of Proposal E, evaluation of evaluations, in that it is a high priority since there are no standards for the mandated county evaluation. Commissioner Poat added that this will provide a framework for future guidelines. Vice Chair Van Horn added that the Master Plan will identify the issues that should be considered.

Public Comment

Mr. Leoni stated that he had spoken with Diane Van Maren of Senator Steinberg's office regarding their performance review. He cautioned against overlapping with the Evaluation Master Plan, and encouraged the Commission to further examine the community planning process.

Ms. Derby declared that NAMI California supports the proposals with the exception of Proposal Z. While MHSOAC needs the results of improving the infrastructure of the status system, NAMI California feels that the state should provide resources to improve state-county interaction. She agreed with Mr. Leoni that communication will prevent duplication.

Commissioner Discussion

Commissioner Pating noted that the Evaluation Master Plan, which Dr. Meisel will report on December 31st, will provide useful indicators for the Commission to track. He supports this motion because it will move the Commission along 75-80% of putting the Evaluation Master Plan infrastructure in place. He encouraged the Commission to continue this process in order to encumber the necessary funds to progress. Vice Chair Van Horn agreed and emphasized the importance of identifying baselines and areas with missing data and outcomes.

Commissioner Poat asked if the Commission approves this proposal, what will happen in the next sixty days. Executive Director Gauger answered that staff will then finalize the Scope of Work. After the bidding and protest processes, the Commission will award the contract.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Brown, the Commission voted unanimously to adopt the Evaluation Committee and MHSOAC staff recommendations of the priority proposals to expend the \$875,000 in Fiscal Year 2012-2013 funds for evaluation as set forth below:*

Proposal J: Evaluation of the Impact of the Community Planning Process through Participatory Research (\$0-\$300,000)

Proposal M: Collection of Baseline Priority Indicator Data (\$0-\$175,000)

Proposal E: Assessment and Improvement of Innovation Program Evaluations (\$150,000-\$200,000)

Proposal Z: Strengthening of Data Collection Systems and Standardized Reporting within the Community Services and Support Component (\$350,000-\$450,000)

10. Details of CalMHSA Proposed Changes to PEI Statewide Plan

Ann Collentine, Program Director of the California Mental Health Services Authority (CalMHSA), stated that CalMHSA's advisory committee and board of directors approved the PEI Statewide Plan. She presented CalMHSA's proposed plan update to MHSOAC as well as to DHCS in July 2012, which included moving \$14.2 million of already-approved funds from contingency and planning funds into program services.

The updated plan seeks to enhance current programs with CalMHSA contract partners. Proposals from the contract partners are due to CalMHSA by October 22nd. CalMHSA staff will complete a performance review of both the standard and new proposals. Staff recommendations will then be presented to a review committee of CalMHSA staff and board members, one stakeholder, and one cultural competency expert for comment, after which it will be presented to the advisory committee for public comment. The updated plan will be submitted to the CalMHSA board at their December meeting for adoption, and brought back before MHSOAC in January 2013.

Commissioner Questions

Commissioner Poat inquired as to what the Commission should expect to see in the January report. Ms. Collentine explained that CalMHSA will present its approval of where the \$14.2 million is to be spent across the programs, consistent and justified according to the current plan, having met the guidelines and principles of the review process. CalMHSA's strategy is to address the gaps in the current plan through this additional \$14.2 million. If the \$14.2 million does not fit within the plan, CalMHSA will develop new plans and new programs to fill those gaps.

Commissioner Poat maintained that CalMHSA is proposing to expend more money on existing plans and dig deeper into areas they already proposed to study. The alternative would be to expand the area of study. He asked how a crucial policy

decision like this was made. Ms. Collentine answered that the CalMHSA board approved this as a plan update, and as such will be working within the existing plan.

Commissioner Poat followed up by asking what evaluation supported this choice to which Ms. Collentine responded that the current plan has areas that need to be addressed through enhanced contracts. Her staff has recommended that a review process is needed to ensure that contractors are performing at an optimal level, whether a plan enhances what is already being done, if it qualifies under the current plan, or if it would be an entirely new one. If it is determined to be the latter, the plan would need to be approved and would need to go through the public process.

Commissioner Poat asked if there was a consensus at the staff and/or board level, on how to spend this money. Ms. Collentine stated that staff determined priorities for spending the funds based on analysis and decided to work under the currently-approved plan to address issues discovered in the operational process through a competitive review process.

Public Comment

Ms. Derby recommended including more than one client/family member stakeholder on the review committee.

11. Presentation of Proposed Statewide PEI Evaluation Framework Developed by CalMHSA

Kate Watkins, M.D., Senior Natural Scientist of RAND Corporation, reported the results of RAND's contract with CalMHSA. MHSOAC coordinated with CalMHSA to seek the development of a statewide evaluation framework for evaluating and monitoring the long-term impact of PEI funding on the population. RAND's tasks were threefold: 1) to develop a strategic evaluation plan for assessing and monitoring the long-term impact of PEI funding on the mental health population, 2) to provide a framework as a foundation that the state, counties, and programs can use to monitor performance improvement, and 3) to focus the framework on reducing the seven negative outcomes identified by MHSA: suicide, homelessness, mental health related incarceration, prolonged suffering, removal of children from the home related to mental health, mental health related unemployment, and school dropout.

A statewide evaluation framework can answer several questions: What did funding achieve? Are the types of programs and populations reached as intended? Is mental health equity increasing? How does California compare to the nation? How do counties compare to each other?

Stakeholder input was essential in developing the framework. RAND conducted interviews with 48 key stakeholders; reviewed progress and draft frameworks with MHSOAC Evaluation Committee and staff, CalMHSA board, and statewide evaluation experts; presented frameworks at county workgroup meetings; and revised approach and frameworks in response to feedback.

The final report contains the background, methods, and rationale for the framework, the analytic approaches, and the key recommendations. The appendices contain the

frameworks, database descriptions, measure specifications for each key outcome, and alternative statistical approaches.

The CalMHSA board has endorsed the report, approved the framework to be utilized for training and technical assistance to counties as a foundational tool for evaluation of PEI, and approved submission and endorsement of the framework to MHSOAC for use and consideration in MHSOAC evaluation activities.

The vision of a statewide evaluation framework is to capture system transformation, monitor progress towards mental health equity, and allow MHSOAC to fulfill oversight responsibility. RAND concludes it is feasible to evaluate the impact of MHSA and PEI findings without the addition of major data collection efforts. The framework will provide important information on current program activities and will establish a basis for longer-term monitoring of program activities and outcomes. Analysis will be descriptive, and will identify gaps between need and program activities, and need and population outcomes.

RAND based the development of the framework on the assumption that reductions in the key outcomes are longer-term, system-wide effects, rather than the direct effects of PEI programs. Changes in key outcomes should be measured for the population as a whole and long-term tracking is essential, although the effects of PEI programs on outcomes cannot be distinguished from effects of treatment. It is essential to collect information about the specific programs that were funded and the utilization and quality of these programs.

RAND created two types of frameworks: the overall approach framework, which highlights the steps between PEI funding and population health at the conceptual level, and the outcome-specific framework which identifies the programs and activities that should be logically linked to specific key outcomes. Both types of frameworks identify the key components to be measured and tracked over time.

When developing an understanding of the impact of statewide PEI funding, RAND felt the framework needed to identify what was being funded, whether those activities made a difference and included public health benefits, and whether the community planning process was inclusive and effective.

When looking at analytic approaches, it is technically difficult to evaluate the causal relationships between PEI program activities and key outcomes. RAND recommends establishing a surveillance system and using descriptive statistics to monitor the effect of PEI and MHSA, supplemented by rigorous evaluations of effectiveness for selected PEI programs.

RAND recommends tracking population-level outcomes, using and strengthening existing data to track population outcomes, standardizing information provided by programs, conducting targeted evaluations and program effectiveness, and developing indicators of program quality and cultural competence.

Commissioner Questions

Commissioner Carrion inquired if there was a way in the system-wide outcome to investigate the linkages between associations, intermediary outcomes, and the final outcome, and if there was any early action to ensure that. He agreed that concentrating on resilience and wellbeing is important, but stated they need to be operationalized because the lack of a definition of “resilience” is one of the challenges.

Dr. Watkins replied that there are three methods to look at linkages listed in the report. In terms of measures of resilience and wellbeing, RAND did a literature review as part of the CalMHSA technical assistance project and identified measures of resilience and wellbeing for both children and adults. Many of these measurements are already in the state databases and are detailed in the appendices in the report.

Commissioner Poat agreed with Dr. Watkins’s surveillance approach, and stated that it will speak to a number of partnerships the Commission will have to create in collecting data on whole populations. He also highlighted Dr. Watkins’s conclusion about resilience and emotional wellbeing and stated that, when standards are set, people start finding improvements over time if that is what is needed.

Vice Chair Van Horn asked where the data bases of the measurements of resilience and well being could be found. Dr. Watkins reiterated that they were in the appendices in the report.

Commissioner Nelson asked what Dr. Watkins’ definition of “well being” was. Dr. Watkins answered that, personally, well being has a lot to do with the ability to function. Can a person go out and do the things they want to do and should be doing? Are they capable of going to work or school? Some people measure well being in the form of feelings such as distress or fear.

Commissioner Nelson asked if these measurements would pertain only to people with a mental illness, or to the general population. Dr. Watkins replied that the measurements could be applied to both. He also questioned what the meaning would be if an individual who does not have a mental illness happens to be feeling down one day. Dr. Watkins stated that it would be an early indication of someone who is at risk.

Commissioner Pating stated that one of the primary interests of the Commission is obtaining county-level data that will be comparable across the fifty-eight counties. He asked if benchmarks were possible to begin to compare the strengths and challenges of certain counties. Dr. Watkins stated that it would be possible to measure boxes 1 and 2 without a lot of new investment.

Commissioner Pating asked, in respect to performance indicators, if there was an area where there can be a unique contribution to the research literature on prevention based on what has been happening in the state, and if there were questions in the general survey that would resolve major research issues.

Dr. Watkins agreed this would be a good area because there has been such an emphasis on cultural competence and it is not known how to measure it well.

Public Comment

Mr. Leoni cautioned that there is another kind of equity besides mental health equity, and that is the equity between clients, the system itself, and those at risk. He stated that comparing programs and elements is how to learn what does and does not work.

Commissioner Discussion

Vice Chair Van Horn stated that RAND's overview approach is important but long-range. He felt Dr. Meisel identified intermediate steps toward a society-level effect in the future. Most of the Commission's evaluation efforts will build toward this point.

Commissioner Pating reminded the Commission that risk factors for mental health coexist with those for smoking, obesity, and cancer. MHSOAC, therefore, cannot consider mental health prevention in isolation. The opportunity to link with other foundations that are working with the same communities will be valuable. RAND has identified ways the Commission can collaborate with these other organizations.

Commissioner Brown asked the Commission to consider the impact of criminal justice realignment on the counties and, in particular, the increased need for mental health services for those who are either incarcerated or under supervision.

12. Commissioner Comments

No Commissioner comments.

13. General Public Comment

Ms. Derby remarked that there are five vacancies on the Commission, one of which is the family member of a youth position, which is particularly important to consumers and family members. NAMI California will be writing a letter to the Governor on this, as the seat has been vacant for over two years. Commissioner Carrion asked Ms. Derby to send a copy of NAMI's letter to the Commission.

14. Recess for Tour of Loma Linda University Behavioral Health Institute

Vice Chair Van Horn recessed the September 27th meeting at 3:16 p.m.

Friday, September 28, 2012

15. Reconvene

Chair Poaster reconvened the meeting on September 28th at 8:39 a.m. He introduced Jerry Wengerd, the Behavioral Health Director of Riverside County and the incoming president of CMHDA.

Mr. Wengerd welcomed the Commission and gave an overview of Riverside County. The population of the county is 2.25 million, and the regional population is 4.5 million. There is a large community of veterans, with active support services.

16. Discussion of the September 10, 2012, Information Meeting and Vote to Adopt Minutes of that Meeting

Chair Poaster decided not to adopt the Minutes of the September 10, 2012, information meeting, because the full Commission was not in attendance at the September 10th meeting. The Minutes will be incorporated into the proceedings of the meeting and the record. He summarized the meeting's focus on PEI and INN programs identified in misleading, inaccurate newspaper articles throughout the state. The hearing was held to correct the misconceptions caused by the articles; the programs were all approved by the Commission as consistent with statute and guidelines. Staff compiled a detailed report on each program, which has been widely circulated within the Legislature, the administration, and the media.

Vice Chair Van Horn asserted that the most important result of the informational hearing was the opportunity for the public to view the unbiased facts. Commissioner Poat added that the Commission acted upon its responsibility for accountability; the agenda today includes further accountability measures.

17. Review of the MHSOAC Policy on Evaluation

Executive Director Gauger stated that the purpose of the presentation is to provide a high-level overview of the policy paper the Commission adopted in November 2010, entitled "Accountability through Evaluative Efforts Focusing on Oversight, Accountability, and Evaluation." When the Commission adopted this paper, there was a decision to shift focus from input by plan review and approvals supporting local program implementation to output by accountability through evaluation.

The primary role of the Commission is to ensure oversight and accountability of the public mental health system. One of the methods the Commission uses to ensure ongoing accountability is through the evaluation of these systems.

Other Commission statutory duties related to evaluation are: to ensure adequate research and evaluation regarding the effectiveness of services being provided; to obtain data and information from the various state departments that have this information, including local entities that are funded with MHSA funds; to ensure that MHSA funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight; and to collaborate with DHCS and CMHPC and consult with CMHDA in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system. This is what is referred to as the Evaluation Master Plan. On this effort, the California Health and Human Services Agency (CHHS) has the lead; staff is working closely with them.

The principles the Commission adopted in this policy paper are such that the Commission's approach to evaluation is focused on quality improvement, is consistent with MHSA objectives, is meaningful to consumers and family members, and is culturally and linguistically competent.

Some of the core questions staff ask as they progress through the evaluations are how the money has been used, what the impact of investments in mental health has

been, and what can be done to improve efficiency and effectiveness of those investments. The Commission currently has \$875,000 per year available to support evaluations.

Commissioner Questions

Commissioner Van Horn remarked that the task to develop the plan was through an amendment made to the MHSA this year. Executive Director Gauger confirmed his statement and added that AB 1467 added the provision that a comprehensive Master Plan will be developed with the collaboration of the DHCS, the CMHPC, and MHSOAC, by consulting with CMHDA. Kiyomi Burchill, of CHHS, is heading this collaboration effort and staff is working closely with this agency.

Commissioner Pating inquired as to who is essentially responsible for the Evaluation Master Plan. Executive Director Gauger responded that when the Legislature made the decision to put this provision into law, Senator Steinberg asked the Commission not to change course, but to continue with their efforts; his intention is to bring CHHS into the fold as lead agency so that they can begin to look across the state as well.

Commissioner Wooton asked if clients and family members are involved in developing the joint plan. Executive Director Gauger stated that Dr. Meisel has held many key informant interviews; a great number of these interviews were with clients and family members. Chair Poaster added that gathering this input is one of the responsibilities of MHSOAC through statute.

Commissioner Wooton stated that she would like to see more clients and family members attending meetings. Vice Chair Van Horn added that one of the issues raised yesterday concerning consumer and family involvement at a policy level was the tendency around the state for consumers and family members to keep quiet about difficult, potentially controversial issues in order to avoid backlash. For true system transformation, a way must be found in which the system is friendlier and more accepting of those who may raise difficult issues. Commissioner Wooton agreed and encouraged the Commission to support any consumer and family member participation.

Commissioner Poat emphasized the Commission's role in ensuring oversight and accountability of the public mental health system as adopted in the accountability policy paper in 2010. Vice Chair Van Horn stated that this role is mandated by law. Executive Director Gauger added that the law specifies the Commission's oversight and accountability responsibility for the adult, older adult, and children's systems of care acts.

Chair Poaster stated that the Commission's current focus is to demonstrate its accountability with regard to the expenditure of voter-approved tax revenues. The Commission may want to revisit this discussion in the future, as the public mental health system is an extensive responsibility. Commissioner Poat agreed and advocated planning long-term to consider future generations of California's evaluation policy while designing this initial generation.

Commissioner Pating stated that the Services Committee is working on an integrated paper regarding co-occurring disorders. The Commission can insert language into this paper to ensure future endorsement of an integrated mental health system with integrated evaluation.

Public Comment

John Ryan, chair-elect of CMHPC, felt that California and federal statutes are unclear on the roles of MHSOAC and CMHPC. CMHPC leadership has requested a policy retreat to discuss the state- and federally-mandated responsibility for outcome measures in mental health services.

Rusty Selix, Executive Director of the California Council of Community Mental Health Agencies (CCCMHA), and Executive Director of the Mental Health Association in California (MHAC), declared that as the principal author of Proposition 63, he acknowledges what Mr. Ryan said. He stated that one of his greatest failures in drafting MHSA was that the relative roles of all the entities were never clarified. This is the reason evaluation efforts are just beginning. It may take the Legislature's involvement to get a definitive answer.

Mr. Wengard stated that CMHDA has also discussed the state- and federally-mandated responsibility for outcome measures in mental health services. The recent change of events in the last year has moved virtually all responsibility back to the county level.

Chair Poaster recognized that the discussion about accountability and evaluation has reached a new level where it is making positive progress. Although MHSOAC is an independent entity, both the Legislature and the administration are in support of the development of a master plan.

18. Presentation of Completed Evaluation Findings

Chair Poaster stated that the purpose of the workshop is to ensure that everyone is on the same page regarding evaluation.

Carol Hood, Retired Annuitant, provided an overview of four evaluation deliverables completed by UCLA Center for Healthy Families and Children and U.C. Davis Center for Reducing Health Disparities.

Evaluation A: Summary of the MHSA Activities and Costs. The Commission contracted with UCLA to summarize both county-specific and statewide activities and costs for FYs 2006-2007 to 2008-2009. A follow-up report for FY 2009-2010 is due at the end of November and will be presented to the Commission in January. The study documented a graduated rollout of components under the MHSA; \$1.7 billion had been expended by the end of FY 2008-2009. It also documented the role MHSA played in the expenditures and the amount of leveraging going on by county. At this time, the focus was on community service and support (CSS) with 98% of expenditures through FY 2008-2009. As required in regulation, a majority of those funds were spent, statewide, on full-service partnerships (FSP). UCLA found that the distinction between the expenditures in the other two categories, general

system development, and outreach and engagement, were not consistent and, therefore, do not recommend continued focus in these areas.

At the time of the study, 25% of the counties had begun implementation of PEI, but 90% of the funds were unexpended. Workforce education and training (WET) included five strategies; almost all the expenditures through this time were focused on staffing and support.

UCLA provided a historic summary of county expenditures by year and by component. More in-depth analyses of specific questions and an additional year's data will be added to the report that is due November 30th.

Evaluation B: Summary and Synthesis of Existing MHSA Evaluations. The Commission asked UCLA to study the impact of MHSA values in existing CSS evaluations to provide the Commission with a base of understanding to know where to focus its efforts. Most of the evaluations were focused on FSPs, where the most robust data is collected. UCLA found studies documenting positive impact for reductions and homelessness and improvement in housing situation, decreased crises and inpatient hospitalization, decreased arrests and incarcerations, improved functioning and quality of life from the client/family member perspective, and improved academic performance and reduced school discipline.

There was less information and existing evaluation findings for PEI. Most of these evaluations are being done at the county level or by their providers and are early in the developmental stage.

Evaluation C: Assessing California's Adult Mental Health Needs. The Commission asked U.C. Davis to study California's adult mental health needs through an in-depth analysis of the California Health Interview Survey (CHIS). They found that 8.3% of adults have a mental health need of serious psychological distress and a moderate level of impairment in one or more domains. The risks increase in younger females with incomes below federal poverty level and no health insurance, who are American Indian or Alaskan Native. Of those who reported a mental health need, 50% saw a primary care or mental health professional for those needs.

Evaluation D: Using Geographic Information Systems to Understand Mental Health Need and Utilization. U.C. Davis did an analysis of penetration rates by census tracts through hot spot analysis, a method for testing the significant clustering of a value geographically. They found there are statistically different levels of access to and utilization of mental health services.

19. Summary of Evaluation Projects and Data Quality Efforts Underway

Dr. Bradley declared that of the six current MHSOAC evaluation projects, the first three or four will be discussed in more depth in the November Commission meeting.

Evaluation Project 1: Data Quality and Corrections Plan. The Commission contracted with California State University, Sacramento (CSUS) to assess the quality of FSP data, which is available via the Data Collections and Reporting (DCR) system. Their objective was to make recommendations on how to overcome the problems

identified with DCR. Information was gathered by interviewing state, county, provider, vendor, and stakeholder groups. CSUS has completed a summary document that highlights limitations, and provides ways to overcome those limitations, such as by creating data dictionaries and user manuals, or offering technical assistance. This document is currently in the stakeholder review period.

Evaluation Project 2: FSP Costs/Cost Offsets. The Commission contracted with UCLA to summarize expenditures of MHSA funds for FSPs and provide lists of per person annual costs, ranged for program services and housing costs for FY 2008-2010. Offsets are based on savings incurred for incarceration, mental health services, and physical health services. The summary will be broken down by year, state, county, and age group. The final report is due at the end of the month.

Evaluation Project 3: Trends in Priority Indicators. MHSOAC and CMHPC have approved a set of priority indicators. The Commission contracted with UCLA to establish trends in those priority indicators for FYs 2008-2009 and 2009-2010, broken down by age group, at state and county levels. The underlying goals are to understand how to measure these indicators given the existing data, to create a reporting template, and to start documenting trends on a regular basis. A report is due at the end of the month followed by another one year from now.

Evaluation Project 4: Impact of Services on Client Outcomes. The Commission contracted with UCLA to study three facets of CSS services: peer support, employment support, and crisis intervention services on individual outcomes. The outcomes they chose to focus on were employment, housing, and wellbeing. UCLA used participatory research to address the issue of impact of services on those outcomes through facilitating a statewide survey and holding forty in-depth interviews. The stakeholder feedback report is due at the end of the month.

Evaluation Project 5: Reducing Disparities in Access to Care. The Commission contracted with U.C. Davis to obtain trends in new admissions to county mental health systems, broken down by age, ethnicity, and gender, and to assess the consumer and family member perspective regarding MHSA impact on reducing disparities, to be done via participatory research.

Evaluation Project 6: PEI. The Commission contracted with UCLA to assess PEI program costs, the numbers served, the spectrum of clients, the program components, and to evaluate the impact of early intervention programs.

20. Overview of Evaluation Master Plan

Joan Meisel, Ph.D., , shared her overall vision for the Evaluation Master Plan. MHSOAC contracted with Dr. Meisel to develop the Master Plan

Review of Evaluation Master Plan Work Plan. Dr. Meisel's work plan is to gather information, draft a plan, and submit a final plan to MHSOAC by the end of the calendar year. She has completed forty stakeholder interviews and four site visits to counties to get a sense of what they are doing in terms of evaluation and data collection. She is reviewing other state evaluation efforts and impacts of federal

developments. Additionally, she will be reviewing other state agency evaluation efforts.

Review of Major Findings to Date. The basic purpose of MHSOAC evaluations is to improve the system over time. The unique role of MHSOAC is to provide information to consumers, state level policy makers, legislators, the administration, and the general public.

Dr. Meisel has found that past evaluation results are used infrequently and ineffectively. There is more data than believed, and it is a question of understanding how to use that information to advance the mental health system; however, existing data is not always fully accurate or comprehensive. Collaboration among those conducting evaluations would minimize duplication and maximize usefulness.

As MHSA funds are integrated into the mental health system, it becomes increasingly difficult to separate the impact of MHSA from the rest of the public mental health system, even more so with CSS funding than with PEI or INN. Also, the variety of evaluation questions will likely require multiple evaluation methods.

Health care reform will necessitate paying attention to new issues, which adds another level of complexity to what this Commission is trying to accomplish. Dr. Meisel is tasked with designing an evaluation system in the midst of what could be very significant changes in the overall way health care services are delivered, which will influence what can be accomplished in terms of evaluation.

Health care reform puts less emphasis on pure mental health evaluation, and more emphasis on health-related outcomes and health care system performance indicators, cost and efficiency, and physical health care cost offsets from providing good behavioral health services.

Dr. Meisel stated that counties are implementing electronic health records, which have been more costly, resource-intensive, and time-consuming than anyone expected. There is a substantial amount of expertise and interest in evaluation at the county level. Some of the focus is shifting from collecting outcome information into short-term, limited-objective kinds of quality improvement efforts. Many counties are developing their own outcome and performance monitoring systems, but are having difficulty getting clinicians to use the information that they are providing.

In terms of the counties' relationship to statewide evaluation efforts, there are ongoing issues with DCR, the system that collects outcome information for FSPs, but there is great appreciation for the work that CSUS has been doing to improve that system.

Dr. Meisel's overall findings indicate great uncertainty. There are continuing evolutions of technology, impacts of health care reform, and state-level changes. However, evaluation cannot be done "on the cheap" if the necessary results are to be achieved.

What the Evaluation Master Plan Will and Will Not Be. The Evaluation Master Plan will build off of the Commission's policies and will provide an ongoing structure. Most

of the evaluation activities that have happened thus far are one-time evaluations. The idea is to provide an ongoing structure that will guide evaluation activities over time. There needs to be some criteria that the Commission can use to prioritize evaluation activities. There will be an initial list of priorities and delineation of a process to update those priorities based on what happens. The Evaluation Master Plan is being developed specifically for MHSOAC.

There are two elements essential to an effective master plan. On the front end, the plan is only going to be as good as the data. There must be a focus on improving the current data system and maybe eventually developing a new way of collecting information. On the back end, the value of doing the evaluation and having an Evaluation Master Plan is only going to be as good as what is done with the information. There must be a focus on how the information is interpreted, and what is done with that information to influence policy in practice.

Scope of the Evaluation Master Plan. The scope of the plan is simply to look at inputs and outcomes. Then, there are basic questions to answer about inputs: Was the stakeholder planning process effective? How has the money been spent? What other factors have influenced the situation while MHSA has been implemented? There are three levels of outcomes: the system level, the community level, and the individual level.

Dr. Meisel warned that evaluation methods are a common area of confusion; she stressed the importance of clarity and the need to be understandable while maintaining technical accuracy. She suggested three methods: monitoring of performance indicators, evaluation studies, and exploratory studies.

Evaluation Method 1: Monitoring of Performance Indicators. This category measures and monitors a characteristic of a population or system. These are point-in-time assessments used to compare across entities or across time to see what the trends are. This is not strictly evaluation, as evaluation looks at input and the impact of that input. Method 1 is a monitoring of system performance. This kind of information raises questions or points out concerns. It can be motivational if benchmarks are set, and it can lead to the identification of good performers.

Evaluation Method 2: Evaluation Studies. This category measures results, effectiveness, or efficiency of a particular effort or intervention. It can evaluate a program, a process, an initiative, or a value. It is not necessary to give up evaluation of values. A particular value can be evaluated to see whether or not it has been implemented or had an effect. The more specific the question, the more effective or useful the impact results will be.

Evaluation Method 3: Exploratory Studies. This category is a response to a question that will help in understanding, monitoring, or evaluating the system and/or outcomes. This is not a strict evaluation study, but it gives information that might lead to an evaluation study or information that is useful in terms of understanding the whole system. Dr. Meisel stated that the study discussed in yesterday's session about the effectiveness of the local planning process is an exploratory study. In that

example, Commissioners discussed the possibility of implementing standards that indicate a local planning process has been effective. If it is determined to be a possibility, then a real evaluation study can be entered into to see what the impacts of those standards are.

Next Steps. Dr. Meisel plans to complete the information-gathering tasks and draft a plan for review, in which criteria for priority setting and a process for revisiting those priorities over time will be included. She will possibly organize the evaluation activities by the evaluation questions and by the evaluation methods. She will establish an original set of evaluation priorities and develop recommendations about how the uses of the evaluations might be more effective.

Dr. Meisel added that clarification of the data systems issues is significant, and will happen while she is finalizing the Master Plan. Her understanding of the legislation is that an agency works with organizations to develop a set of client outcomes. Values, client issues, system issues, and community issues focus on client outcomes. Dr. Meisel has found, through her research for the Evaluation Master Plan, that there is a consensus about the importance of client outcomes. She encouraged pursuing clarification of responsibility and agreement amongst all of the constituencies as the place to start.

Commissioner Questions

Vice Chair Van Horn asked if Evaluation Method 1 and Dr. Watkins's "surveillance," referred to in yesterday's session, are the same thing, and how Dr. Meisel sees her work combining with that of Dr. Watkins for CalMHSA. Dr. Meisel answered that in terms of performance indicators, Method 1 seems the most similar. The major contribution of the RAND framework is in community-level impacts which are on people who need but have not received any direct services. RAND has brought this population into attention.

Commissioner Pating recommended that the Commission should narrow its scope of focus before expanding it. He asked how the Commission's oversight and accountability function can be highlighted, particularly in the issue of measuring funding for multiply-funded programs. Dr. Meisel answered that there will need to be studies on cost offsets with regard to health care, more exploratory studies about ways to pay for mental health care, and increasing health care outcomes in performance indicators. There can also be questions about specific functions within MHSA. Chair Poaster added that these issues are critical in health care reform.

Commissioner Poat declared that this is one of the central policy questions. This may be generations away, but the Commission should begin looking at holistic investments. For example, the Commission could, in the future, measure physical and mental health by region and form appropriate plans to connect with funding sources.

Commissioner Pating agreed that on the federal level, systems of care have been developed based on funding, rather than on optimal outcomes. He suggested

focusing on the outcomes before ensuring the policymakers, including MHSOAC, fund those outcomes.

21. Public Comment

Debbie Innes-Gomberg, of CMHDA and the Los Angeles County Department of Mental Health, reiterated that collaboration with counties is essential in order to increase service quality and improve clients' lives. She agreed that an ongoing structure, as opposed to one-time studies, is the approach to take, and would like to see decisions based on quality data and outcomes in addition to an ongoing dialogue.

Mr. Wengerd commented, on behalf of CMHDA, regarding Dr. Meisel's statement on how evaluations can not be done properly "on the cheap". He argued that realignment of funds will make it difficult for counties and emphasized the need for an integrated approach. He asked Dr. Meisel to ensure that the plan is contained in a single, effective system of data reporting that will work for California.

Ms. Derby stated her support of Commissioner Wooton's comments regarding meaningful client and family member involvement in the evaluation discussion and in the collaboration between MHSOAC and the other named organizations. She asked to include state hospitals and other localized, long-term institutions in the evaluation.

Mr. Selix emphasized that evaluation is one of the most important things specifically singled out in MHSA. In writing MHSA, he envisioned it guiding amendments to guidelines and funding the counties. He did not anticipate the tension that has been created by the desire to defend MHSA, which has prevented exposure of weaknesses in the expenditure of funds. He recommended providing comparative information to consumers; most necessary information has been compiled by inpatient involuntary hospitalizations and outpatient penetration, by year and by county. There is not enough information available to evaluate INN yet.

Mr. Selix added that the Commission's role, in terms of how MHSA was written, came from the Little Hoover Commission reports, which predated MHSA by three years and addressed all mental health care. That is how Commissioners were chosen. MHSA is meant to fill in the gaps for everything that is needed, and to make recommendations on what everyone else needs to do to get there. Integration must be the focus, to the level where each primary care patient is screened and evaluated for undiagnosed issues. This is the time, with significantly increased funding on its way, to develop new three-year plans. The Commission has a role in making that happen.

Commissioner Pating asked Mr. Selix where the 5% set-aside for evaluation funds came from. Mr. Selix answered that the intent behind the 5% MHSA fund for evaluation, now 3.5%, was that it be taken at the state level; however, counties will need to spend some of their own money as well. He added that, in his opinion, doing the evaluations in the most cost-effective, fund-saving manner will answer the immediate needs strategically.

22. Commissioner Discussion

Chair Poaster stated that staff will be compiling comments and ideas, and a summary will be presented in the afternoon session. Staff has provided a series of questions to help facilitate the discussion.

1. Is evaluation of statewide investments in the MHSA still a driving strategy in oversight and accountability?

Chair Poaster acknowledged that the evaluation policy adopted in 2010 does not recognize limits or prioritize strategies for oversight and accountability through evaluation. He requested Commissioners' thoughts regarding alternate ways to execute oversight and accountability.

Commissioner Pating pointed out that there are also influential policy statements the Commission can make. He suggested using the policy pulpit to frame issues in order to set a goal for accountability.

Commissioner Carrion suggested that since evaluation and performance monitoring are distinct, it might behoove the Commission to monitor programs in their early stages. Commissioner Nelson suggested also evaluating outcomes.

Commissioner Poat asserted that the Commission should remain the champion of evaluation. Championing speaks to the overall system, not just MHSA. He applauded the work of the Commission and the Chair thus far, and encouraged the Commission to continue working toward a statewide consensus on evaluation.

Commissioner Pating and Vice Chair Van Horn agreed that, while the Commission can influence policy, stakeholders and other organizations are ultimately responsible for consensus. Vice Chair Van Horn recommended that the Commission focus on combining successes into an integrated system to influence program development as well.

Chair Poaster noted that the discussion had not yet considered the policy shift of mental health from state to county level and the devolution of the funds that went with it. He disagreed with Commissioner Poat's statements related to the breadth of what the Commission is doing. The values of MHSA say that policy decisions rise through local communities, but this is not happening in reality. All resources and risks pertaining to mental health services have become the responsibility of county boards of supervisors and this issue needs to be acknowledged. Commissioner Poat stated that while he does not agree with the statement of giving everything to the counties, he does agree that counties are best equipped to make decisions. He added that the state should have an accountability framework related to measured outcomes and regarding its portion of the funding.

Chair Poaster countered that things can not be both ways. The Commission can not do everything. MHSA funding is just a small part of the overall mental health

system and in fact most of that funding has been appropriated to the local level already.

Commissioner Poat conceded that MHSA funding is a small part of the overall mental health system. He added that it was his belief that the evaluation system being referenced today is not just MHSA, but mental health services which is a legitimate policy question that needs to be addressed. MHSA funds can not be solely considered in regards to this issue, but the overall public health care system as well. He cited his knowledge of the public transportation system in which there is federal, state, and local monies supporting a variety of things. He stated that he would like to see outcomes supported by an assortment of funding sources like these.

Chair Poaster clarified that the devolution of funding was related to who establishes policy because MHSA funding is just a small part of that bigger picture.

Commissioner Nelson suggested basing policy on the results of some of the exploratory studies Dr. Meisel discussed. Commissioner Pating also suggested combining the different perspectives of the counties and MHSOAC as an ongoing conversation. He recommended keeping an open process to achieve the Commission's goals.

Commissioner Wooton opined that evaluation results should be transparent. She warned that sometimes the input of clients and family members' differs in the reporting from what is actually said. She attributed the differences to the summarization of evaluation results. She also encouraged including the community planning processes in the evaluation of program effectiveness and agreed with Mr. Selix in that clients and family members need to know the value of a program before becoming involved.

Vice Chair Van Horn advised that the policy shift must preserve statewide elements in Medicaid and Medi-Cal to maintain a cohesive system. CiMH is setting up learning collaboratives to encourage counties to learn from each other. He agreed that the Commission's scope should be clarified, involving constituencies to look beyond "the public system" and into the effects on the population.

Commissioner Carrion urged that evaluation systems need to be flexible. For example, there can be evidence of improvement in an individual within a program, but that program may not be the agent of change. Variables need to be addressed. The question is whether the Commission has the resources to oversee this complex system. It would be beneficial to create a timeline for this.

Commissioner Poat suggested developing a Work Plan next year motivated by the unified evaluation system, with the goal of legislation by the end of the year budget proposals.

2. What are the evaluation results so far telling us about MHSA implementation?

Vice Chair Van Horn noted that evaluation results indicate reasonable outcomes in a range of areas. There will be a baseline by the end of this coming year, which will highlight improvements made over the last eight years.

Commissioner Pating encouraged the Commission, while focusing on evaluation, to consider other tools. Long-term, California is moving toward an integrated system. At a policy level, the system is going to become more confusing, and he urged the Commission to discuss that. While the current priority is to study and protect MHSA funding while moving toward this longer-term goal, conversation will create the level of commitment that will facilitate practical decisions in the future.

Commissioner Poat agreed and added that there are two generations to think of now: the first is the interim process, and the second is the integrated systems outcome approach.

Chair Poaster opined that the conversation Commissioner Pating spoke of should include the organizations that are working on these issues currently. He added that while the Commission is pontificating, these people are stepping in and making it work. It would behoove everybody to follow that practical example.

Commissioner Poat declared that MHSOAC should be a champion. If the Commission accepts this role as a champion, then it can advocate for convening partners and stakeholders to have these conversations. He pondered if a proposal, with consensus, can be reached by February or March when legislation is introduced. He specified that the Commission does not want to tell anyone what to do, but instead be a champion for consensus.

Commissioner Pating stated that evaluation has thus far indicated that implementation dollars for FSPs are well-spent, but this has yet to be demonstrated in other programs. Commissioner Carrion added that evaluation results do not report what services are available, what the best services are in the population, or what it would take for implementation and dissemination of promising services. He recommended creating a timeline to begin this process.

3. What critical information, resources, or coordination among organizations should be included in the Evaluation Master Plan?

There were no comments made that pertained to this question.

4. Beyond evaluation, reviewing MHSA plans, and approving INN plans, should the MHSOAC focus on other strategies for oversight and accountability?

The following are strategies by Commissioners:

- Influence policy
- Ensure collecting and tracking of data and information
- Ensure that counties are provided appropriate support

- Ensure MHSA funding and services comply with relevant statutes and regulations
- Utilize evaluation results for quality improvement
- Communicate the impact of MHSA

Public Comment

Ms. Innes-Gomberg agreed with Chair Poaster's comment about meeting with the organizations currently working on these issues and expressed her wish to be included in those discussions. She felt that the Commission did not have all the necessary information to make some of the decisions discussed today. With regard to PEI, some of the early results coming out of Los Angeles have been very positive around six evidence-based practices and in looking at positive pre-post differences in terms of CMHDA evaluation. CMHDA will increase the value of PEI results by using RAND's eight elements of emotional wellbeing, in order to report those results in ways that communities can understand. She added that CiMH learning collaboratives have been instrumental in understanding and using the data.

Mr. Ryan stressed that the most important thing that needs to be looked at is what happens between the consumer or family member and the clinician. It would be valuable to provide clinicians with tools to determine if treatment is working so that they can adjust to ensure effective services.

Mr. Wengerd informed the Commissioners that CMHDA is reconstituting a group of people to work on outcomes that can be structured in light of health care reform. He recommended staying connected during the integration process.

Mr. Selix praised Mr. Ryan's comment that the relationship between the clinician and the direct line consumer applies to all Californians. This is the scope of this Commission's responsibility and what MHSOAC was originally created to focus on. CCCMHA, the state association of providers that contract with the counties, is working collaboratively with CMHDA to present a framework to MHSOAC, demonstrating a way to collect program-level data that works from all perspectives.

Ms. Derby pointed out that MHSA was not written to be confined to one funding stream, and that implementation of services within the counties is mixed within it. It would be invalid to focus only on MHSA outcomes within a mixed system. She encouraged including client and family member input in all of the collaborations on integration. The client and family member voice should be included to avoid any future conflict and to help support these processes.

Commissioner Wooton stated that through the process of MHSA, program development, and implementation, clients and family members should have input before a draft form is in place.

23. Review Morning Discussion and Possible Next Steps

Staff Member Carol Hood summarized the main points from Agenda Item 22.

Evaluation is the driving strategy in oversight and accountability by the Commission. However, it is not sufficient; additional tools need to be maintained to complement

evaluation. Evaluation findings need to be disseminated and used to promote promising practices, to support quality improvement, to give people ideas on how they can change, to identify where change needs to be made at the state level in terms of policy, and to be a champion of evaluation.

There is much energy and effort in evaluation. MHSOAC can take a major role in keeping that energy going. There was discussion about the scope of evaluation, the changing environment, and the role of MHSOAC and others regarding MHSA and the broader public mental health system. There was also discussion about the changing roles between the state and county and how that has been a factor with oversight and accountability and integration with the all-important system-changing health care reform.

There was discussion about the challenge that resources will present. There was discussion and consensus about coordination and collaboration around evaluation, both from the public comment and from the Commissioners. MHSOAC may have a very specific role in ensuring the authentic voice of clients and family members from the beginning and throughout all of these discussions and collaborations regarding evaluation.

In terms of next steps, there needs to be additional discussion on MHSOAC role on MHSA and the broader system. Dissemination of best practices and other evaluation findings remains critical. Once the Commission accepts Dr. Meisel's recommendations on the Evaluation Master Plan, the Commission will need to develop specific next steps to understand where the Commission is going now, and why it has the broader vision of the second generation. There were some suggestions for things that could be included in evaluations, discussion of promising practices, and emphasis on the impact of evaluation where it matters most, in client/clinician interaction.

Commissioner Discussion

Chair Poster asked Ms. Hood where the disseminated information was gleaned. Ms. Hood answered that this information can be gathered on best practices by utilizing Dr. Meisel's third method of evaluation, exploratory evaluation; Ms. Innes-Gomberg was also gathering some information. Vice Chair Van Horn added there are six best practices that have moved through the county; development of information can begin in evaluating those best practices. Most counties are at the very beginning of the evaluation of their PEI programs.

Commissioner Wooton emphasized that it is important for the Commission to be involved in a task force or with CMHDA or another entity to facilitate integration with health care reform. Vice Chair Van Horn agreed and encouraged Commission involvement that spans the groups responsible for evaluation of various elements of the system, including the health system. Commissioner Pating stated that the open-ended questions to address after health care reform rolls through are, what the system will look like later on, and how it impacts services.

Chair Poaster encouraged the Commission to act quickly, as these events are already in motion in other states in both private and public sectors. Commissioner Poat echoed his earlier statement that the Commission can make an impact through legislation and budget proposals. He suggested a timeframe for accomplishing as much consensus as possible. He recommended that the Commission have the conversation of what will be evaluated by whom, with the goal of submitting budget change proposals by next August, and submitting legislative proposals to be codified to the Legislature a year from now.

Commissioner Pating indicated that the health care reforms are on the Governor's desk, awaiting signature; the Commission will soon know the structure of basic decisions around health care reform. He suggested convening CMHDA, CiMH, the agency, consumers, and MHSOAC in the first quarter of next year to discuss the scope of open-ended questions to see what the issues are, before laying out a framework. At that point, the Commission can draw upon other states' models. Additionally, he imparted his idea of the evaluation strategy as moving ahead with evaluation through the Master Plan, having a set of conversations that will look at where MHSOAC evaluation touches up against a larger systemic approach to evaluation, and then having longer-range conversations.

Commissioner Poat inquired as to what the Commission is going to do in the interim and what the span of the interim actually is. Vice Chair Van Horn informed Commissioner Poat that the interim is from now until significant implementation of health care reform, which starts in 2014 and is fully developed by 2017. Workforce development is going slowly and will not be in place by 2014 unless graduate schools move things ahead or there are alternatives for certificates.

Vice Chair Van Horn asked Mr. Ryan if CMHPC will partner with MHSOAC in workforce development in preparing for 2014-2015. Mr. Ryan replied that with OSHPD taking over, the amount of money being devoted to stipends across all disciplines has been allocated to fund students. OSHPD has convened a consumer group to discuss future efforts, but, other than some counties funding their own stipends, he was not aware of any other efforts occurring at the state level. OSHPD will report to CMHPC in two weeks on their future plans. CMHPC is directly involved with OSHPD on this. OSHPD has a year to do the second five-year plan, and CMHPC encouraged them to do an evaluation of the first five-year plan to determine what was and was not accomplished.

Commissioner Pating shared that the Services Committee hopes to propose a technical assistance resource center as a place to coordinate and work with other agencies, in addition to working on a way to provide a dissemination structures of identified best practices as a function. He added that CiMH has a website to post the Master Plan Evaluation results of best practices.

Chair Poaster suggested that the Commission focus on best practices. He attributed CiMH as the largest exporter of best practices and stated that they would be a good resource to utilize.

Commissioner Poat suggested updating the evaluation policy paper with the discussions held today, including questions in the identified areas that need work in the year ahead; the Commission could then consider this updated version at the next meeting and move to a Work Plan for next year that begins to address some of those open issues.

Vice Chair Van Horn gave notice that staff will begin drafting the Work Plan next week. He asked staff, as part of that process, to augment the evaluation policy paper for the November meeting. Dr. Meisel stated that she will present a draft of the Master Plan at the November 14th Evaluation Committee meeting.

Chair Poaster suggested amending the evaluation policy paper after the Master Plan reforms it.

Vice Chair Van Horn stated that it is helpful for the Commission to look at things that are in progress. Dr. Meisel will present a large amount of material in November; if the evaluation guide paper can be updated by that time, the Commission will be in a position to make some decisions.

Commissioner Poat reiterated that in order to begin any implementation in the next cycle, the Commission needs to adopt a framework by June at the latest; required budget changes and legislative proposals need to be advocated by late summer. Regulatory changes can be considered anytime. This timeframe will enable the Commission to move into an implementation position the following year. Executive Director Gauger asked to meet with the Chair, Chair elect, and the Vice Chair elect to discuss priorities in order for staff to meet this timeframe.

Commissioner Poat opined that the work plan, timeframe, and framework should be the main focus of the Commission for the next year. Commissioner Pating recommended next year's main focus be implementing Dr. Meisel's Master Plan. At that point, the Commission can begin conversations about integrated evaluations, and if there are results by June, as a deliverable, then that can move forward in the legislation or budgetary requests. Commissioner Poat echoed that the Commission needs to establish a functional framework.

Vice Chair Van Horn added that Commissioner Poat had suggested that with regard to questions surrounding evaluation and the Commission's role in it, more of the Commission meetings be workshop meetings in the coming year. Additionally, given how much needs to happen before January 1, 2014, there may need to be more than the usual five or six Commission meetings. Vice Chair Van Horn suggested having monthly meetings or two-day meetings every other month.

Commissioner Pating asked to add, "To foster and promote an integrated mental health system" under Agenda Item 23, question #3. Vice Chair Van Horn asked Commissioner Pating how the system would be integrated. Commissioner Pating answered that it could be either integrated mental health system or integrated whole health system.

Commissioner Wooton asked for clarification on what will be proposed, as integrated systems of care refer only to MHSA and the Medi-Cal services.

Commissioner Pating clarified that the Service Committee is working on writing an extension of the co-occurring paper. There are several levels of integration: the integrated care experience for the client; integration across MHSOAC from INN to PEI to community supports and services; integration of the evaluation of the mental health system; integration through health care reform and regular health care; and integration of mental health and all these other systems. One of the goals of the Commission is to promote integration in order to ensure that consumers receive appropriate care and are given necessary resources without regard to where they are in the system.

Commissioner Poat suggested that Chair Poaster ask MHSOAC Staff if they had any key questions that would enable them to put together a concept; the elements of which would consist of a 2013 work plan that results in a discussion of the accountability framework among all interested parties focused on the effectiveness of PEI programs and Services for individuals living with mental illness.

Chair Poaster stated that as Chair of the Commission until January 1 of next year, he will work with the chair-elect on what the next steps for the Commission will be, but only after he receives some clarification on a few issues.

Public Comment

Ms. Derby suggested including the perspectives of the Office of Health Equity and California Reducing Disparities in evaluation efforts. Chair Poaster declared that the chair-elect will resolve the overlap in responsibilities between MHSOAC and the Office of Health Equity.

24. Adjourn

Chair Poaster adjourned the meeting the September 28th at 1:47 p.m.