

MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
July 26, 2012

Citizen Hotel
926 J Street
Sacramento, California 95814
866-817-6550; Code 3190377

1. Call to Order

Chair Poaster called the meeting to order at 9:10 a.m. He reviewed the agenda.

2. Roll Call

Commissioners in attendance: Larry Poaster, Chair; Richard Van Horn, Vice Chair; Sheriff Bill Brown, Ralph Nelson, Jr., Andrew Poat, and Eduardo Vega.

Not in attendance: Victor Carrion, Senator Lou Correa, Assembly Member Mary Hayashi, David Pating, and Tina Wooton.

A quorum was established.

3. Adopt Minutes of the May 24, 2012, MHSOAC Meeting

Commissioner Vega stated “recovery and” should be added before “resiliency” in the presentation on participatory research evaluation deliverables.

Motion: *Upon motion by Commissioner Poat, seconded by Vice Chair Van Horn, the Commission voted unanimously to adopt the May 24, 2012, Meeting Minutes as amended.*

4. Update on the Adopted 2012-2013 State Budget Act

State Perspective

Kiyomi Burchill, Assistant Secretary of the California Health and Human Services (CHHS), provided an overview of the enacted 2012 State Budget as it impacts MHSOAC, as follows.

Overview of the Budget

On June 27th, 2012, Governor Brown signed the 2012-2013 Budget Act, which closed a budget deficit of \$15.7 billion, through \$8.1 billion in reductions and \$6 billion in revenues, and rebuilt a reserve of \$1 billion. These figures assume the passage of the Governor’s temporary tax measure, the Schools and Local Public Safety Protection Act. The budget gap was also closed by \$2.5 billion in other solutions that, along with the \$1 billion reserve, totals \$16.6 billion.

The budget also assumes passage of the Governor’s initiative on the November ballot, which will provide revenue as well as a Constitutional protection for CHHS

county partners that are implementing public safety realignment. Public safety is defined broadly and includes Medi-Cal Specialty Mental Health services to the counties.

If the governor's tax initiative does not pass, there are triggers built into the budget totaling \$6 billion that go into effect in January 2013. These are primarily for schools and community colleges.

Reorganization of the Department of Mental Health

In January, the governor's budget proposed a reorganization of behavioral health at the state level. Under the proposal, the majority of community mental health functions from the Department of Mental Health (DMH) were transferred to the Department of Health Care Services (DHCS), concurrent with the majority of programs from the Department of Alcohol and Drug Programs (ADP). CHHS sees this as the first step in integrating mental health, substance use disorders, and physical health administratively at the state level to improve the overall health status of individuals with these needs.

The enacted budget made progress towards this reorganization by eliminating DMH, establishing the Department of State Hospitals (DSH), and transferring the community mental health functions to DHCS. The reorganization of ADP was delayed by one year to July 2013.

The community mental health functions from DMH were transferred to departments within CHHS and MHSOAC. CHHS envisions DHCS as the policy leader on community mental health within the administration. DHCS has recently created a division for mental health and substance use disorders (MHSUDS).

MHSA Budget Clarifications

Assembly Bill (AB) 100 was passed as part of the 2011-2012 budget and began streamlining MHSA programs. Enacted changes to MHSA and AB 100 significantly limited the state's administrative fiscal role. Reflecting that shift to the counties, 123 positions were eliminated at DMH. As a part of the 2012-2013 budget, the Governor also signed AB 1467, the Health Omnibus Trailer Bill, on June 27th. Its provisions of law went into effect immediately.

The trailer bill included a number of clarifications for MHSA. These were previously included in Senate Bill (SB) 1136, authored by Senator Steinberg. SB 1136 received a policy bill hearing in the Senate Health Committee and passed off the Senate floor with a 39-0 vote.

Key Provisions from SB 1136 in AB 1467

In terms of county MHSA plans, the trailer bill made clarifications regarding the three-year expenditure plans and annual updates. This includes that the county Board of Supervisors will approve these county plans and that counties will submit them to MHSOAC no later than thirty days after adoption by the Board of Supervisors. Additionally, counties under these provisions will certify compliance with provisions of MHSA and that expenditures are consistent with MHSA.

In terms of the funding mechanism for MHSA, one of the changes enacted as part of the 2011-2012 budget in AB 100 is that the State Controller's Office (SCO) will distribute the unexpended and unreserved funds in MHSA fund to each Local Mental Health Service Fund established by counties each month starting July 1, 2012. AB 1467 clarified that the distribution of funds would be pursuant to a methodology developed by DHCS, wherein DHCS would inform MHSOAC and the California Mental Health Directors Association (CMHDA) of that methodology.

There were provisions related to coordination on evaluation and for an Evaluation Master Plan that provides that CHHS will lead a joint planning effort with MHSOAC, DHCS, the California Mental Health Planning Council (CMHPC), and CMHDA to design a joint plan for coordinated evaluation of client outcomes in the community-based mental health system.

AB 1467 codified current innovation guidelines and clarified, in terms of approval by MHSOAC, that counties could expend funds upon approval by MHSOAC, which, under the current funding mechanism, was not consistent.

The Workforce Education and Training (WET) component was transferred to the Office of Statewide Health Planning and Development (OSHPD) and established a deadline for the next five-year plan which OSHPD will be tasked with.

AB 1467 codified the Revenue and Expenditure Report, and provides that counties will submit this report to both MHSOAC and DHCS.

Realignment of Medi-Cal Specialty Mental Health

The Medi-Cal Specialty Mental Health program was realigned as part of the 2012-2013 budget. Last year, as part of public safety realignment, other programs were realigned to the counties because of the one-time use of MHSA funds in 2011-2012. The budget implemented a permanent allocation structure for future realignment revenues, and the governor has asked for a Constitutional protection on the November ballot.

Questions and Discussion

Chair Poaster thanked Ms. Burchill for her presentation. He requested that she explain the transfer of responsibility for ADP programs. Ms. Burchill stated that the Deferred Maintenance Program (DMP) and Medi-Cal Specialty Mental Health, in the 2011-2012 budget, were approved for transfer in July 2012, and that transfer of responsibility has occurred. DMP is now part of MHSUDS of DHCS. ADP is still in effect, as its transfer was delayed for one year. The state budget approved transfer of the functions of ADP to departments within CHHS effective July 1, 2013.

Commissioner Poat asked if the Legislature has provided a delivery date for the Evaluation Master Plan. Ms. Burchill stated that there is not a delivery date specified in statute for the Evaluation Master Plan.

Commissioner Vega asked, with regard to the newly-structured department, what the mechanism will be for bringing the expertise of clients, consumers, and other stakeholders into the process of the deliberation, policy, and program decisions.

Ms. Burchill stated that the governor-appointed deputy director for MHSUDS at DHCS will begin the process of engaging stakeholders.

Vice Chair Van Horn asked Ms. Burchill if she had clarified her sense of what the role of the MHSOAC is with DHCS and others vs. the role of CMHDA. He added that the Commission has been prepared to move ahead in developing an Evaluation Master Plan and has engaged the expertise of Dr. Joan Meisel as outcomes of evaluation services has developed. He postulated that the Commission should keep Ms. Burchill updated on everything from this point on. Ms. Burchill affirmed that the Commission should keep her updated and stated that CHHS is in the preliminary stages of understanding and taking inventory of the work that is being done by the entities that are specified in statute. Vice Chair Van Horn suggested, as part of CHHS's inventory phase, identifying the necessary changes to the data systems in use in order to gather realistic information. Ms. Burchill agreed.

Public Comment

Steve Leoni, of the Mental Health Association in California (MHAC), stated he is concerned that discussion regarding mental health is fractured, looking at parts without relating them to a whole. While he understood that there is a mandate for interagency agreements, he suggested a stakeholder process that acts as a bridge to keep the discussion robust and moving forward.

5. Budget Impact on MHSOAC, Implications of Senate Bill 1136/Assembly Bill 1467, and MHSOAC Approach to Innovation Plan Approval

Executive Director Gauger stated the budget directly impacts MHSOAC in three ways:

- Five stakeholder contracts were transferred from DMH to MHSOAC. These contracts total \$5 million over a three-year period, which equates to \$1.6 million per year. Two of the contracts with the United Advocates for Children and Families (UACF) will expire June 30, 2013. A contract with the National Alliance on Mental Illness (NAMI) and a contract with the California Association of Local Mental Health Boards and Commissions (CALMHB/C) will expire June 30, 2014. A contract with the California Network of Mental Health Clients (CNMHC) had been managed by DMH but was terminated. Staff is in the process of writing a RFP. That contract will now go out to an open bidding process.
- The amount of the California Youth Empowerment contract was increased by \$50,000, and then added to MHSOAC's budget, where it now totals \$300,000.
- The budget provides for a \$1 million continuous appropriation to support the Commission's evaluation efforts.

Executive Director Gauger summarized key provisions from SB 1136 that are now in AB 1467:

- MHSOAC is to receive all program and expenditure plans, as well as the annual Revenue and Expenditure Reports.

- Some of the Innovation guidelines that MHSOAC had previously approved have been codified.
- MHSOAC is to review and approve innovation program plans.
- MHSOAC and DHCS are to jointly establish performance outcomes for services in collaboration with CMHDA.
- The provision of the Revenue and Expenditure Report has now been codified.
- MHSOAC, in consultation with CMHDA, will administer the instructions.
- MHSOAC is to be consulted by DHCS when developing regulations.
- MHSOAC is to design a comprehensive joint plan for a coordinated evaluation.
- In collaboration with DHCS, CMHPC, and in consultation with CMHDA, CHHS is to lead the comprehensive effort.
- MHSOAC retains authority to write guidelines for Prevention and Early Intervention (PEI) and Innovation.
- MHSOAC, in collaboration with DHCS and in consultation with CMHDA, is to assist in providing technical assistance to accomplish purposes of the community services and support programs.

Executive Director Gauger stated that the MHSOAC Evaluation Master Plan is on target to be completed no later than December 31, 2012.

Other Changes to MHSA

AB 1467 was a budget trailer bill. Since the last Commission meeting, the provisions that were in SB 1136 were added to AB 1467 along with a few changes. The Governor signed AB 1467 on June 27th, 2012, and it became effective immediately. Part of the result of that action is that MHSOAC will no longer have until January to get the Innovation review and approval process in place.

One change in AB 1467 from SB 1136 impacts the Commission by deleting "at risk" and adding "diverse community members reflective of California populations" to the description of the population for which the Commission must ensure that perspective and participation are a significant factor in the Commission's decisions and recommendations.

Two provisions have been added in AB 1467 that have an impact on MHSA:

- The five-year WET programs shall include promotion of meaningful inclusion of community members of diverse races and ethnicities, who are underrepresented in the mental health provider network.
- Counties are to demonstrate a partnership with constituents and stakeholders throughout the three-year program, expenditure plan, and annual update process that includes meaningful stakeholder involvement in mental health policy,

program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations.

Implementing the Commission's Role in Innovation Plan Review and Approval

Executive Director Gauger stated, in terms of the proposed approach for MHSOAC to review and approve the Innovation plans, staff has updated the Innovation Review Tool to reflect new statutory references. The Innovation Guidelines are now in the Code, so everything that is in the tool is now tied directly to statute.

Questions and Discussion

Commissioner Vega asked Executive Director Gauger what agency the contract with CALMHB/C funds. Executive Director Gauger stated that the contract with CALMHB/C provides funding for individual county mental health boards to meet on a quarterly basis and sets parameters around the amount of money they can spend on those meetings. Commissioner Vega asked if it is individual county mental health boards to which Executive Director Gauger answered yes. He also questions if it was the planning council to which Executive Director Gauger answered no. Chair Poaster added that historically it was not a contract that the Commission has had in the past.

Commissioner Poat stated that in order for MHSOAC to administer contracts, it should have the opportunity to review the expectations and parameters before adopting the purposes and funding of these contracts. Executive Director Gauger stated that the contracts will remain as they are until they expire, at which time MHSOAC will evaluate the deliverables. Staff has set up internal processes to monitor and verify tangible deliverables before payment will be issued.

Commissioner Poat recommended that since MHSOAC is responsible for these contracts, Commissioners have the opportunity to look at the framework and to understand the objectives, the selection process, the evaluation, and what the contracts are going to accomplish. He asked Executive Director Gauger if it was possible to provide the Commission with a report sometime this Fall on how it is proposed to proceed with the administration of contracts with a particular focus on the two contracts that expire in June 30, 2013. Executive Director Gauger answered affirmatively adding that she would be happy to provide a proposed scope of work and recommendations in relation to the continuation of contracts.

Chair Poaster stated that in the past, DMH and MHSOAC have both had similar contracts with the same organizations at the same time. He added that there is concern that those similar contracts need to be evaluated as a whole and the deliverables have to be supported and developed. The contracts should be more deliverable-based to accomplish the goals of the legislature and the administration in asking the Commission to administer those contracts. The Commission must take a comprehensive look at what these contracts do, and to do that, the Commission needs to educate itself in what they contain and what the deliverables are.

Vice Chair Van Horn agreed that Commissioners should know what the contracts contain and what the current deliverables are.

Commissioner Poat stated that when contracts are being administered, transparency is the best approach; and since MHSOAC is the Commission that is held responsible, it should vote at some point to adopt a process, expectations, and accountability standards.

Vice Chair Van Horn stated that these advocacy contracts have existed from before Proposition 63 and were handled out of the director's office at DMH. There were limitations to what could be done because advocacy organizations feel threatened by the funding and service sources. MHSOAC is independent of other parts of the administration, so the contracts can be administered in an advocacy-transparent manner that has not been possible before. As these contracts are redesigned, they can include guarantees that give safety and solace to the organizations who engage in the contracts in the future, with written assurances that positions they feel they need to take as advocates are reprisal-free. The contracts being transferred to MHSOAC can ensure a solid advocacy role within a system that has at times been difficult to maintain.

Commissioner Vega stated that this is an important opportunity for California and that he is hesitant about continuing the contracts inherited from DMH without a clear review process. He added that he wants to make sure that the Commission takes advantage of the opportunity to use these resources to benefit California and have an empowered stakeholder base and to support and develop better and more effective advocacy.

Chair Poaster added that he agrees with that Vice Chair Van Horn's statements about the contracts administered by DMH, but in his opinion, these contracts are in existence to implement MHSA and all of the act's requirements on stakeholder participation. If a discussion is needed, then the Commission will have one, but he is concerned about the broader advocacy of things outside the purview of the act. He stated that his intent would be to help clarify and develop specific deliverables as opposed to wide open expectations that might not be important.

Commissioner Poat asked Executive Director Gauger if the joint plan for coordinating evaluation would be discussed in the Fall. Executive Director Gauger stated that the meeting would be held in September and would be a day-and-a-half meeting with one of those days being devoted to Commissioners having a workshop around evaluation. Chair Poaster added that it is the Commission's intent to move ahead with the Evaluation Master Plan. The September meeting is to fine tune the Commission's thoughts on the evaluation process. AB 1467 requires after approval by board of supervisors that those plans be sent to the Commission within thirty days. He asked Executive Director Gauger what the expectations of the Commission were after the plans are received and approved.

Executive Director Gauger stated that the expectations are not clear in statute. She opined that in terms of her conversations with legislative staff and others that there is a role for the Commission to play consistent with oversight and accountability. Staff are going to devote considerable time in looking at the other components to determine what the Commission should be cognizant of. She gave the example of

receiving a plan that has not been approved of the county Board of Supervisors. She added that Staff will also use the plans as a means to track and monitor these programs and trends.

Vice Chair Van Horn asked if MHSOAC has the staff to handle the potential volume of paper or e-mails the plans will entail. Executive Director Gauger stated Staff will explore the possibility of entering into a contract to get help designing the tracking system so that staff can load it into a database. In the future, additional resources may be necessary, but right now it is focusing internally at how to best use current positions.

Public Comment

Diane Van Maren of Senator Steinberg's office stated that the Senator's intent was to provide a balanced approach in this legislation, which required a review of the streamlining process begun last year with AB 100. AB 100 lowered the administrative threshold and led to transition with respect to DMH.

Part of the streamlining process was to provide for the county Board of Supervisors to approve the annual updates as well as the three-year plans. It was Senator Steinberg's intent to have those plans sent to MHSOAC for oversight, review, and data analysis. If there are concerns or issues at the local or state level, with respect to the expenditure of Proposition 63 funds, MHSOAC continues to have the authority to bring them forward to DHCS as well as to the Legislature, in order to strengthen Proposition 63.

Senator Steinberg also continues to focus on the performance contracting provisions to add transparency and to provide information to strengthen the overall framework, which requires the counties to have performance contracts with DHCS.

Senator Steinberg sees the Commission as continuing to pursue the Evaluation Master Plan. He also sees Agency coordinating efforts within the administration working together, as many aspects of Proposition 63 need to be evaluated through stakeholders, MHSOAC, and the administration. Ms. Van Maren stated there may be connections between mental health managed care, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and what is coming forward as well, and she is optimistic about the federal health care reform efforts. Senator Steinberg's idea was to collaborate and coordinate and to have more of the partnership that was delineated in statute.

Mr. Leoni expressed concern that, since a particular contract regarding public involvement in Commission meetings was canceled after December, there has been no mechanism enacted to replace it. He appealed to MHSOAC to ensure all actions affecting the client community are intended for healing the divisions between factions; he suggested mechanisms to organize the community by preventing poor leadership and building a strong network.

Jim Gilmer, of CMMC, the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), and the African American Strategic Plan Workgroup, stated that he appreciated Vice Chair Van Horn's comments on advocacy; advocacy without

reprisals brings more people to join with the public mental health system. He added that he looks forward to the changes brought about by such contracts.

Kathleen Derby, MHSA Policy Coordinator of NAMI, stated her appreciation for the discussion of transparency and the effectiveness of the contracts. She clarified that NAMI represents consumers and family members equally. Although many of the contracts are not based upon deliverables, NAMI is developing its own set of deliverables to submit to MHSOAC; NAMI looks forward to the opportunity for greater involvement in MHSOAC meetings, in order to serve the community most efficiently, and requested advance information to make this possible.

Stacie Hiramoto, Director of REMHDCO, emphasized the need for advocacy through these contracts, and urged MHSOAC to consider involvement and engagements in deliverables. Several years ago, REMHDCO requested funding for consumers, family members, and representatives of underserved communities; Ms. Hiramoto renewed that request in light of current contracts. She hoped to work closely with the Commission in ensuring stakeholder involvement at a local level in performance contracts and building empowerment among the community.

Rusty Selix, Executive Director of MHAC, stated that one way to compensate for Staff resources in plan review is to send collected documents to statewide stakeholder groups for comments; while this will generate a large response, it will highlight which areas need a more thorough review. This will also bring focus to significant, useful changes and trends.

6. Presentation of UCLA Draft Deliverables: Full Service Partnership Cost, Cost Offset, and Priority Indicators

Introduction to the UCLA/EMT Draft Reports, Part 1

Staff Member Carol Hood began the discussion on two draft reports for stakeholder input: one on cost and cost offsets for the Full Service Partnership (FSP) clients, and one on Priority Indicators.

In 2010, the Evaluation Committee developed a recommended course of action for utilizing the \$2 million in resources granted to MHSOAC for Evaluation. The Commission has since approved the approach and provider qualifications for these resources. Staff conducted a Request for Proposal (RFP) process that recommended the Commission develop two contracts with UCLA.

The two draft reports for stakeholder input show data at the aggregate or statewide level and include data from counties that verified accuracy. The stakeholder input period begins today and will last thirty days, with the final report due in September 2012.

FSP Cost and Cost Offset Report covers the annual and daily expenditures of FSP. This is the first time this information includes all four age groups, and the first time costs based on actual expenditures and daily enrollment have been reported. Cost offsets are based on a comparison between one year pre- and post-enrollment in critical areas for new enrollees. The full reports are available on MHSOAC website.

(A fire alarm interrupted the meeting from 10:50 a.m. to 11:04 a.m.)

Initial Statewide Priority Indicator Report

Elizabeth Harris, Ph.D., of the Evaluation, Management, and Training Associates (EMT), stated there is normally a distinction between expenditures and costs, but for the purpose of her presentation, the two terms will be used interchangeably, as will "offsets" and "savings."

EMT has been charged with identifying the statewide and annual county cost per day, annual cost by age group, and savings realized when FSP services are provided, in order to quantify the cost of FSP services and resultant savings per age group.

Savings, while not the sole reason for the study, were a primary objective as an accountable, public service; interim objectives included identification of where and for what age groups savings occur. The report Dr. Harris presented was a draft for the counties that have participated thus far; the full report will be released in the fall 2012 and will contain additional offset areas, and include more participating counties. EMT optimized the use of existing data, such as the data in the statewide Data Collection and Reporting System (DCR) as well as collected expenditure data. The use of these data to form a comprehensive picture of the impact of statewide FSPs was another interim objective.

Thirty-seven counties participated in the draft report. EMT began by reviewing the Revenue and Expenditure Report data, and FSP line items; however, these reports cannot determine FSP cost by age group. For this, EMT sought guidance from an evaluation advisory group, which determined that the counties themselves were best able to track FSP costs by age group. Therefore, EMT developed a web survey, and the county responses formed the age group data.

Fiscal Years (FY) 2008-2009 and 2009-2010 were examined because of their comprehensive DCR data, the outcome variables of which can be used to determine cost offsets. Fifty-eight counties had the cost offset data available initially. Four counties have returned the survey regarding FSP costs by age group; EMT has extended the deadline for the survey to August 3rd.

EMT reviewed FSP costs for program services and housing in order to document client support. There were five line items listing housing expenses; the web survey was used to determine how much was spent on housing in each age group in each FY. Outreach was not included, as counties felt it inaccurately inflated the cost of FSPs.

Regarding the cost of service in the two FYs, FSP participants were documented according to start and end dates of service within the FY. The calculations for costs are explained in the draft report. The total costs by age group and FY are subject to change, depending on information gathered from additional counties' survey responses. Dr. Harris noted FSP program stability is highlighted in overall annual and daily cost comparisons for the two FYs, the similarities within each age group, and the drop in figures for all age groups from one FY to the next.

EMT also reviewed where the majority of funds are spent. Adults are most often served, spend most of the funding, and occupy most of the days of service.

Cost offset analysis is limited to new enrollees to encompass a comparable period of service in the baseline intake assessment of twelve months prior to enrollment. Using DCR, EMT gathered consequence data for the baseline intake assessment and compared the pre-intake twelve-month period with the post-enrollment twelve-month period. Cost offsets were calculated per individual, each analyzed in only one FY.

FSP cost offset preliminary funding include an adjustment to account for time. The formula for calculating offsets is in the full draft report online. Overall, approximately seventy percent of the overall costs are offset by savings to the system.

EMT found that, while adults represent the largest cost category, most offsets within the age groups come from the adult group, which shows that FSP resources are being used wisely. When the two FYs are combined, the savings within the age groups, excepting children, families, and youth (CFY), come mainly from the psychiatric area, followed by incarceration and physical health.

Dr. Harris invited Commissioners to e-mail their questions or comments no later than August 26th, to allow time for revision to the final report due on September 30th.

Questions and Discussion

Commissioner Van Horn asked what percentage of costs go to housing and how is the housing provided. Dr. Harris answered that the report has all of the cost figures in it and could not recall what the percentage was. She recommended that Vice Chair Van Horn consult the report. In answer to how the housing is provided, it is a the discretion of the individual counties.

Commissioner Nelson asked if the report contained definitions of terms used. Dr Harris answered affirmatively.

Commissioner Vega requested a comprehensive pie chart depicting all expenditures and offsets in each category.

Vice Chair Van Horn asked if any individual was followed in both FYs. Fred Springer, Ph.D., of EMT, answered that since the baseline data is one-year retrospective, EMT annualized everything that happened for clients in the program beyond their entry date. Therefore, an individual in the program for two years had their rate of occurrence for different events annualized back to one year. However, the longevity of impacts, while expected to be higher in the first year, is unknown; this analysis will be possible as longevity is reviewed.

Vice Chair Van Horn then asked if EMT had a way to track the savings and treatment costs of a client in the program for the two years studied. Dr. Springer stated that the data collected makes this possible. Vice Chair Van Horn stated that CMHDA has been pursuing a levels approach like the one implemented in Los Angeles. While the case rate can be measured, analyses of the costs in the various levels are not reflected in reports, since clients may have been in the program for

several years. It is important to understand how to measure cost offsets as a client's situation improves.

Commissioner Nelson asked if the report accounts for clients who dropped out of the program. Dr. Harris stated that DCR documents the number of people who did not complete the program; this number can be added to the final report.

Commissioner Vega asked if it is reasonable to project total savings for all of California from the data collected, which Dr. Harris felt would be possible in the final report. Dr. Springer added that standard statistical extrapolation can account for the counties not surveyed. The final report will include a statewide estimate.

Commissioner Brown asked how arrest data was compiled and whether it was verified, and what methodology was employed for the criminal justice cost savings. Dr. Harris stated clients are asked for the number of arrests at intake and each subsequent follow-up period. This will be included in the final report, along with all sources, which are in most cases OSHPD, the California Department of Corrections (CDCR), and the counties themselves. Commissioner Brown cautioned that clients may give incorrect information regarding the number of incarcerations and that the fixed costs for each facility may make the numbers misleading.

Introduction to the UCLA/EMT Draft Reports, Part 2

Ms. Hood stated that MHSOAC intends to provide semiannual reports of priority indicators; these indicators were approved by CMHPC, which has the statutory authority to approve performance outcomes, and by the Commission.

EMT determines which indicators have priority and how best to measure them. Implementation of regular reports on priority indicators remains a work in progress; it is important that feedback be provided in this draft. In previous reports, EMT put approved priority indicators into action, proposed alternatives, or suggested potential additions. In this report, EMT provided preliminary findings using county-verified data.

Initial Statewide Priority Indicator Report

Dr. Springer stated that whereas the prior report had input from expert advisory councils, this report had different criteria and is primarily the outcome of a participative process designed for county input. This report is intended for monitoring the outcomes of county activities over time, and will specify priority indicators to determine how clients benefit from services at an individual level and how well the system operates as a whole.

With the overall goal of creating a system with this kind of measurement, the objectives of this report were to review ways to improve performance and outcome monitoring through methods of measuring priority indicators, to inform MHSOAC on the success of measurements, and to identify effective methods of gathering data.

The participative process was designed to gather stakeholder input regarding valid indicators for assessing their activities. EMT identified the strengths and

weaknesses of previously developed priority indicators, assessed existing data sources, and identified a set of indicators for which potential valid information exists.

A conceptual level of assessment preceded this deliverable. EMT reviewed initial priority indicators, made revisions based on stakeholder feedback, and reported the results to the Commission. EMT then identified potential existing data sources for priority indicators which brought together available data for these indicators for the first time. The process was conceptually-driven and participative. To date, the process has not independently included criteria for priority indicator appropriateness, systematically applied criteria for data quality, or applied any criteria for potential analytic strength.

EMT went through a data quality assurance process, largely participative, with stakeholder feedback. Between the twenty-eight counties that responded, there was a variety of perceptions concerning data validity. Comparisons across FYs should also be interpreted with caution due to substantial variation in the data received.

The indicators were conceptually defined on consumer and system levels. On the consumer level, the report defines what influences participation in the program, and what impacts the program will have upon clients' lives. On the system level, the report details the efficiency and quality of care provided through the system.

Questions and Discussion

Commissioner Vega asked if there is a way to track which participants are involved specifically in MHSA services and programs. Robert Blagg, Ph.D., of EMT stated some indicators required evaluation of mental health consumers overall and FSP consumers specifically. Ms. Hood added that there is no way to distinguish what the MHSA funded.

Commissioner Poat recommended that rather than assessing strengths and weaknesses of the data, keep a record of what is learned throughout the process. This would enable better choices to be made while establishing goals, programs, and evaluations. MHSOAC may have to set investment categories, and will need to consider ways to generate data of the best quality.

Ms. Hood stated the difficulties that UCLA/EMT encountered in data quality and usability were unexpected. She felt that maintenance of current data collection systems while developing new ones is an important step towards the Evaluation Master Plan. Dr. Springer agreed that UCLA/EMT must balance what is desired and what is feasible in gathering data. The participative process must emphasize a dialogue between technical capabilities.

Commissioner Nelson asked if people on all levels of the recovery scale responded appropriately, and if the consumer perception surveys include people who are incarcerated or institutionalized. Ms. Hood responded that each data source has its own challenges and groups included. FSPs are some of the most intensively served. The consumer perception surveys are sent to people within the system, who were satisfied with access.

Commissioner Vega asked if the twenty-eight counties included in the report constitute the majority of Californians. Dr. Blagg answered that they did constitute a majority, as Los Angeles was one of them. The report contains a regional breakdown of the counties into different mental health regions.

Commissioner Vega asked if consumers who have participated in the survey can be empowered by the resulting information. Ms. Hood stated that one of the charter items of the Evaluation Committee is to better disseminate evaluation findings. Discussion is ongoing in the new evaluation section of their website. Commissioner Vega challenged the Commission to actively ensure consumers receive the results of surveys.

Public Comment

Ms. Derby stated that it is important to NAMI, consumers, and family members to consider the experiences of people in various institutions. She suggested actively involving counties and service providers in the dissemination of evaluations and results, and questioned why county participation in the surveys is voluntary.

Philip Hanger, Ph.D., the Executive Vice President of Clinical Services of Mental Health Systems (MHS), commented on the FSP report, recommending there be a non-FSP group with which to compare offset costs. He suggested delineating data by type of evidence-based practice, as is done with FSP in San Diego County. Dr. Springer added that the rating of quality of service will allow analysis of counties' use of evidence-based practices.

7. General Public Comment

No public comment.

8. Amendments to MHSOAC Rules of Procedure

Filomena Yeroshek, Chief Counsel of MHSOAC, summarized eight proposed amendments to MHSOAC Rules of Procedure:

- Rules 1.3 and 1.4 propose that the time of the election of the chair and vice chair be moved from the fourth quarter to the third quarter to allow more time for the development of the following year's work plan.
- Rule 5.1 proposes that the incoming Commission chair will appoint the Committee chair and vice chair to allow more time for the development of the following year's work plan.
- Rules 1.1, 4.9, and 4.11 clarify that language is directly from the Bagley-Keene Open Meeting Act, or MHSA.
- Rule 2.1 deletes reference to DMH because DMH no longer exists.
- Rule 4.13 exempts Innovation plan approval from the second reading requirement. The amendment is needed because AB 1467 provides that the Commission is now approving Innovation plans. After AB 100, when that

approval was deleted, the rules were changed to delete the exception. This amendment reinstates that language.

Questions and Discussion

Commissioner Poat suggested that since the Commission will be issuing contracts, there should be a contract section in the rules. Counsel Yeroshek stated there is a contract delegation of \$200,000 for interagency agreements and \$100,000 for non-agency agreements.

Chair Poaster suggested the amendments to Rules 1.3 and 1.4 be changed to specify September or any meeting within the fourth quarter.

Public Comment

In reference to Rule 4.13, Mr. Leoni recommended providing full notice regarding the absence of a second reading for Innovation plan approvals to ensure time for people to comment.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Poat, the Commission voted unanimously to adopt the amendments to the MHSOAC Rules of Procedure, Rules 1.1, 1.3, 1.4, 2.1, 4.9, 4.11, 4.13, and 5.1.*

9. CalMHSA Proposed Changes to PEI Statewide Plan

Ann Collentine, Program Director of the California Mental Health Services Authority (CalMHSA), stated that the CalMHSA update plan draft will be posted for public input until August 4th. She gave an up-to-date status report on the implementation of the updated plan and stated that CalMHSA is currently finalizing contracts for community colleges and suicide prevention (SP) implementation, under Work Plan Amendment 1. The implementations include additional grants that provide communication on mobile devices for transition-age youth (TAY) for SP and a Spanish language hotline in the northern area.

CalMHSA has nearly completed its first year of implementation. Through CalMatrix, the data management system, CalMHSA is on track with eighty-six percent of deliverables as of March 31st. The dashboard will be available in September 2012. For the deliverables not on track, CalMHSA followed up with each contract manager to determine if corrections needed to be made to technical assistance. Fifty-two percent encountered problems in completing tasks related to the deliverables in their contracts, mostly due to late startup. CalMHSA hopes to develop a more comprehensive dashboard that will include fiscal information.

In CalMHSA's particular initiative, 965 students, staff, and faculty were trained in the SP program and twenty-three CSU campuses were awarded sub-awards focusing on vets, students of underserved communities, and peer-run support organizations on campus.

The Student Stigma and Discrimination Mobilization Campaign launched the Reachout online forum in May. CalMHSA has also launched statewide public

service announcements (PSA) regarding reachout.com, a chat board and blog providing information about mental illness and mental wellbeing. In September, they will launch an SP media campaign called "Know the Signs, Suicide is Preventable," as well as a PSA competition on SP for K-12 students throughout California. The winning entries will be presented in May 2013 during May Is Mental Health Month, a red carpet event in Sacramento.

Ms. Collentine stated the plan update was posted on July 5th. This update proposes the move of \$14.2 million into program services from already-approved funds and the implementation plan. Of the \$14.2 million, \$9.6 million will come from the operating reserve and \$2.8 million from the planning fund.

CalMHSA staff intends to strengthen existing statewide PEI programs. Any new programs proposed for funding must be posted for thirty days for public comment and be approved by the MHSOAC.

In the plan update, CalMHSA recommends continuing to use their key principles to determine funding priorities from the first work plan amendment in March 2012. These include:

- Maintain overall consistency in the proportion of funds allocated to SP (25%); Stigma and Discrimination Reduction (37.5%); and Student Mental Health (37.5%).
- Strengthen local and regional capacity by ensuring new CalMHSA participants are included in funded activities.
- Strengthen racial, ethnic, and cultural competency within existing projects.
- Implement PEI projects in an expeditious manner.
- Expand the scope of regional projects to include additional geographic areas and underserved populations.
- Consider the unique characteristics of communities participating in CalMHSA, including local factors such as capacity, population, and setting.

To plan for sustainability and maximize the impact and legacy of CalMHSA projects, staff recommends two additional principles for this plan update:

- Consider performance, sustainability, and leveraging opportunities to maximize available funding.
- Enhance capacity for data-driven decision making and contribute to the body of knowledge of emerging PEI best practices to improve student mental health, prevent suicide, and reduce stigma and resulting discrimination.

Staff recommends the addition of these new principles in order to plan for sustainability and maximize the impact and legacy of CalMHSA projects.

It is anticipated that SP will increase by \$3.6 million, and Student Mental Health and Stigma and Discrimination Reduction both by \$5.3 million.

Using these principles, CalMHSA will set up a review tool for proposed programs. CalMHSA is also in the process of evaluating the cultural competency of their program partners. They will have information about this within the next six months. CalMHSA will prioritize the recommendations on these projects based on the principles, will adjust them as necessary through the vetting process to augment funding to go before the Advisory Committee for additional feedback, and, based on that feedback and the authorization from the board, enter into contract negotiations. Ms. Collentine hopes the majority of contract enhancements will be completed by the end of the year.

Questions and Discussion

Chair Poaster stated Commissioner Vega has recused himself from discussion as his organization is a contractor with CalMHSA.

In response to Chair Poaster's question, Ms. Collentine stated that the reversion issue on the funds has not been solved and CalMHSA is still in negotiations with DHCS.

Chair Poaster asked if the \$14.2 million will fund services other than those currently in the plan. Ms. Collentine stated that as part of the current assessment and aligning with the principles of the original plan, broader populations may be reached through translation of materials or the use of multiple-language media campaigns.

Public Comment

Ms. Hiramoto stated her concern about the quick turnaround, since the plan update was posted only through the Advisory Committee agenda and there was no general notice to CalMHSA stakeholders. She was also concerned that the principles have little specificity as to cultural competence and the serving of underserved racial and ethnic communities with these grants. She stated that the members of REMHDCO would like to work in partnership with CalMHSA, but feel they cannot keep up.

Mr. Gilmer stressed the importance of outreach and engagement in strengthening racial, ethnic, and cultural communities and stated that this is where collaboration can be most effective.

10. Client and Family Leadership Committee

Report Findings and Recommendations from 2011 Community Forums

Commissioner Vega briefly stated that community forums were launched in 2010. In 2011 three forums were held with a new structure established for forum design and implementation. This new structure included an eight-member Community Forum Workgroup (CFW) involved in a continuous quality improvement process. The process embraces feedback received in the form of anonymous survey questionnaires given to participants at the end of each forum who's answers provide information necessary to assess experiences, outcomes, and forum participation. Commissioner Vega summarized the goals for the community forums:

- To provide opportunities for MHSOAC to hear firsthand from clients, family members, and other stakeholders about their experience with MHSA in communities across California, including what is working and what challenges still exist
- To expand public awareness and education about MHSA and MHSOAC and its role
- To gather and collect information and stories about local experience and impact of MHSA
- To expand the visibility of MHSOAC, including areas of the state where the Commission does not usually meet
- To summarize and analyze the data gathered, which will inform the Commission's decisions, strategic directions, and actions in the future

Commissioner Vega stated that there were three major changes implemented in 2011: a new structure, new sets of questions, and intensified outreach to the typically un-served or underserved from various racial, ethnic, and cultural communities.

A significant amount of information, both positive and negative, is gathered and documented in these forums. Many people are served by MHSA, enrolled in MHSA programs, or connected in ways of which they are unaware. CFW asks questions regarding whether or not MHSA is transforming communities and how the gathered information can be used to develop and enhance its effectiveness. These forums have been a positive way to connect to people and raise the visibility of the Commission and MHSA.

Commissioner Vega summarized the consistent findings among forum participants:

- The majority of comments were positive.
- Respondents identified the most effective services as housing, peer support, peer providers, employment, and culturally-competent services.
- More mental health providers from racial and ethnic communities are necessary.
- There is concern about services or lack thereof.
- The community engagement has less impact than when MHSA began.
- TAY expressed interest in the Commission and mental health policymaking and is concerned they were not being represented on MHSOAC.

Commissioner Vega summarized the findings that prompt additional Client and Family Leadership Committee (CFLC) attention:

- There is a need for more crisis intervention training for law enforcement and a broader system of working effectively with law enforcement.

- Forum participants reported significant success from client and family member employment in the mental health system and from peer provider programs.

As a result of these findings, CFLC focused on gathering information on crisis intervention training, developing strategies for the promotion of client and family employment, and providing guidance and clarification.

Motion: *Upon motion by Commissioner Vega, as the Client and Family Leadership Committee Chair, the Commission voted unanimously to adopt the recommendations contained in the 2011 MHSA Community Forum Report.*

Commissioner Poat stated the forums are effective because of informal discussion, which MHSOAC meetings do not facilitate; he requested restructuring of future meetings to include a period of time for this type of discussion.

Public Comment

Ms. Derby agreed that the community forums can be effective, but the effectiveness depends on the outreach. She emphasized the importance of incorporating the information from the forums into future policies, and of making reports to participants regarding how that information was implemented.

Ms. Hiramoto asked the Commission to balance the benefits from the forums between the Commission and the underserved communities. She believed the members of the Cultural and Linguistic Competence Committee did not receive a copy of this report and were not able to offer suggestions and amendments. She agreed that the demand for interpretation services, as described on page six of the report, is important, but added that there is also a demand for more bilingual mental health staff. She recommended MHSOAC speak with Dr. Sergio Aguilar-Gaxiola and the California Institute for Mental Health (CiMH) regarding alternative ways of reaching the community.

Mr. Gilmer stated his appreciation for the opportunity for outreach, but added that he felt the dialogue could be enriched by small groups and personal interviews. He encouraged collaboration in order to gather precise information and resolve some of the issues in the findings shared today.

11. MHSA Workforce Education and Training: Current Transition Activities and Future Goals

Chair Poaster introduced the panel of representatives from OSHPD, CMHPC, and CMHDA.

Office of Statewide Health Planning and Development (OSHPD)

Stephanie Clendenin, Chief Deputy Director of OSHPD, provided an overview of OSHPD in the role of administrating MHSA Workforce Education and Training (WET) programs. OSHPD is one of fourteen departments in CHHS agency with a vision to provide equitable healthcare accessibility for California. It is a specially-

funded organization with 175 positions and focuses on three main areas of healthcare: construction and financing, data collection, and workforce.

There are two programs within the department that focus on the healthcare workforce. These programs focus on four areas:

- Awareness and placement, to attract individuals to health professions, provide training opportunities, and to find placement in California's rural and underserved areas.
- Financial incentives, to provide funding and grants for training and education programs to prepare graduates for service in areas of unmet needs, and to place health professionals in those areas.
- Data collection, under the Healthcare Workforce Clearinghouse Program, to serve as a central repository for healthcare workforce data, and bring together health education licensing and employment data, and education and training program data.
- Systems design, to deliver health services.

The Health Workforce Development Division focuses on the distribution, diversity, and competency of California's healthcare workforce. The programs within this division encourage demographically underrepresented groups to pursue health careers, particularly in areas of unmet need, and encourage primary care physicians and non-physician practitioners to provide healthcare in health professional shortage areas in California.

The Health Professions Education Foundation is unique to the department and is a 501(c)(3) non-profit public benefit corporation that was created by the Legislature in 1987. The Foundation is advised by a board of trustees, whose mission is to improve healthcare in underserved areas of California by providing scholarships, loan repayments, and programs to health professional students and graduates dedicated to providing direct patient care in those areas.

Lupe Alonzo-Diaz, Executive Director of Health Professions Education Foundation, emphasized the commitment of OSHPD in assuring that the administration of MHSA WET programs is indicative and reflective of the mission, vision, and values of the original MHSA. She introduced the programs and discussed their activities.

Current funding and expenditures are consistent with previous ongoing multi-year contracts. The current five-year WET Development Plan consists of partnership, program development, and financial incentives strategies. OSHPD has administered the Mental Health Loan Assumption Program and the Song-Brown Physician Assistant Mental Health Special Program since FY 2008-2009.

The programs have engaged in traditional technical activities as well as broader actions, including evaluating feedback from stakeholders and developing an Advisory Committee. OSHPD has also developed the next five-year plan, and issued a Psychiatric Residency (RFP) for expansion of these programs.

California Mental Health Planning Council (CMHPC)

Brian Keefer stated that CMHPC has worked with OSHPD since 1999. CMHPC has the opportunity to reexamine the building of functions in California's Behavioral Health Workforce System to meet the needs of the state, and to work with OSHPD to examine the effects of financial incentives on enrollment capacity in statewide educational programs.

The greatest success of these efforts has been in local mental health programs, counties, and regions. They have created career ladders and engaged participants in distributive education. This success is largely due to the voluntary work of small counties. CMHPC looks forward to enacting the next five-year plan.

California Mental Health Directors Association (CMHDA)

Molly Brassil, Associate Director of CMHDA, spoke from a statewide perspective about the local and regional implementation of WET investment. Nearly all counties have completed and implemented local WET plans; their varied approaches reflect the unique challenges faced by geographically and culturally diverse counties. The limited evaluation of statewide contracts will be an opportunity to ensure strong coordination between local and statewide projects.

Ken Crandall, of the Superior Region WET Partnership, stated the Superior Region has a small population and a large geographical area, which creates challenges in the recruitment and retention of staff. The Superior Region WET Partnership prioritized support of planning, development, and implementation of distance learning systems, to attract consumers and family members to the workforce. They will also encourage strengthening of curricula in the region to support wellness and recovery principles, and will identify resources to support accessible training and technical assistance (T/TA), focus on wellness and recovery, and the availability of distance-education formats.

CMHDA has worked with Humboldt and Chico State Universities to develop distributed education programs. The Superior Region Partnership also funded the Shasta Center out of Chico. This fall, Chico State University will begin its distributed education program. CMHDA hopes to have the mentoring program in place before start of the next semester. They are also exploring opportunities to coordinate with CalMHSA for PEI projects.

Questions and Discussion

Commissioner Poat asked in light of the workforce program completing its first five-year plan, what would happen to the partnership at the completion of the ten-year period. Vice Chair Van Horn stated counties may dedicate money to sustain the program at a local level, but there is not a statewide grant as of yet.

Commissioner Vega stated he was glad to hear that recovery is part of the curricula. He asked that stigma and discrimination be included as well, since those issues are prevalent in SP and the general mental health culture. He added that there are few

health providers throughout the country that practice suitable SP and because of this, he feels that training should be part of the statewide licensure requirements.

Public Comment

Ms. Derby stressed the need for a workforce that is responsive to the needs of the community and emphasized the linguistic and cultural needs of underserved populations. The strengthening of the program will increase and support the employment of consumers and family members within the public mental health system, and will help eradicate stigma and discrimination. She encouraged further collaboration with a focus on education.

Russell Vergara, Co-Chair of the California MHA Multicultural Coalition (CMMC) and faculty member at USC School of Social Work, commended MHSOAC for its efforts in enriching curricula, and recommended evaluating stigma in training by examining community-based practices of underserved communities. He urged the Commission to include community-defined practices in the curricula to promote practice innovation, stigma elimination, and meaningful engagement.

Mr. Leoni stated that the recovery-oriented system MHSOAC is moving toward will be a great improvement on the current system. He requested ensuring that clients and family members are a part of WET activities as trainers and content experts. He recommended requiring certain recovery content be in the curricula, in order to prepare students for the reality of the situations they will face with clients.

Sandra Marley, advocate and consumer, agreed with Mr. Leoni on requiring recovery content in curricula; she felt including this requirement in scholarships would be effective. She urged MHSOAC to look outside understaffed counties in order to select applicants for the master's program who hope to move into a rural community.

Ms. Hiramoto applauded OSHPD's work with underserved communities and consideration for consumers and family members. She mentioned "The Pathway Program - Restoring Hope to Rural Communities by Creating Access" and their inspiring work and success in changing culture.

12. Client and Family Leadership Committee

Second Read: Proposed Adoption of Recommendations on Accessibility of MHSOAC Meetings

Commissioner Vega stated that the Commission had reviewed the draft paper with the recommendations by CFLC and confirmed that the requested clarifications had been included in the revised document.

Commissioner Poat cautioned that the issue of free parking should not create any difficulties with public transportation access. Commissioner Vega clarified that there will be balance with transit access, and this consideration will not be a barrier to potential meeting locations.

Commissioner Vega moved for adoption of the recommendations as listed in the revised report. Chair Poaster suspended the vote until after the public comment period.

Public Comment

Executive Director Gauger clarified that the revised draft incorporates recommendations made at the last Commission meeting.

Ms. Derby emphasized the need for ensuring informational accessibility as well as physical accessibility; she asked how the Commission and advocacy organizations could work together to distribute information in a timely manner. Executive Director Gauger stated that Commission staff delivers information to stakeholders and posts materials in the timeframe required by law; Commissioner Vega suggested tracking and highlighting changes in revised documents. Commissioner Poat added that subscribers are notified when MHSOAC website is updated.

Mr. Vergara applauded the Commission's efforts in reaching out to the community; he urged the Commission to continue to make meetings accessible to as much of the public as possible in order to facilitate meaningful involvement.

Motion: *Upon motion by Commissioner Vega, as the Client and Family Leadership Committee Chair, the Commission voted unanimously to adopt the recommendations contained in the Client and Family Leadership Committee Analysis and Recommendations Regarding Accessibility of MHSOAC for Clients and Family Members, July 2012 report.*

13. MHSOAC Executive Director Report

Chair Poaster announced there will be no Executive Report today.

14. Commissioner Comments – reserved for Commissioners to identify matters for future Commission business

No Commissioner comment.

15. General Public Comment

No public comment.

16. Adjourn

Chair Poaster adjourned the meeting at 4:39 p.m.