MHSOAC
Mental Health Services
Oversight & Accountability Commission

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State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
January 24, 2013

Members Participating

Richard Van Horn, Chairman
David Pating, M.D., Vice Chairman
Senator Lou Correa
Assemblymember Bonnie Lowenthal
Sheriff William Brown
Victor Carrion, M.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph. D
Andrew Poat
Tina Wooton

Members Absent

David Gordon
LeeAnne Mallel

Staff Present

Sherri Gauger, Executive Director
Aaron Carruthers, Chief Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Kevin Hoffman, Deputy Executive Director
Renay Bradley, Research and Evaluation Chief
Norma Pate, Administrative Chief
Jose Oseguera, Committee Operations Chief

1. CALL TO ORDER/ROLL CALL

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission to order at 9:05 a.m. and welcomed everyone. Administrative Chief Norma Pate called the roll and confirmed the presence of a quorum.

Chairman's Remarks

Chairman Van Horn welcomed Assemblymember Bonnie Lowenthal, the new Assembly- appointed Commissioner, and announced the new Governor appointees David Gordon, Superintendent of Schools, Sacramento, LeeAnne Mallel, Licensed Psychological Technician, Office of Dr. Jonine Biesman and the reappointment of Dr. Larry Poaster.

2. APPROVAL OF NOVEMBER 15, 2012, MINUTES

ACTION: Vice Chairman David Pating made a motion, seconded by Commissioner Carrion that:

The Commission approves the November 15, 2012 minutes as presented.

- Motion carried, 10-0

3. ADOPT 2013 COMMITTEES CHARTERS

Chairman Van Horn asked the chairs of each Committee to present their Charter objectives and key activities for 2013. The following charters were presented:

a. Client and Family Leadership Committee

Commissioner Nelson stated that the objectives of the Client and Family Leadership Committee (CFLC) are to increase the participation of clients and family members in the operation of the organization, to have the respective participation reflect client and family values, and to have activities where the CFLC can learn from consumers and families. The Committee plans to continue the community forums in collaboration with the Cultural and Linguistic Competence Committee (CLCC). There will be four forums in 2013, as well as reports documenting prevalent themes noted in each one. Commissioner Nelson anticipated presenting an annual report in October. CFLC will work with stakeholder advocacy groups on strategies that will increase stakeholder participation in the process. CFLC will also continue with the crisis intervention law enforcement survey throughout the State to see who is, or is not, performing crisis intervention training.

b. Cultural and Linguistic Competence Committee

Commissioner Carrion stated that the main objective of the CLCC is to have meaningful, increased, and diverse participation of all communities in the State and to ensure their input is included in the decisions and recommendations of MHSOAC made throughout the year. In collaboration with the CFLC, the CLCC will continue to work on the quarterly community forums and diversify the methods by which input is received. As a part of that, the CLCC will conduct a self-assessment to track progress in terms of following the culturally- and linguistically-appropriate services (CLAS) recommendations.

c. Evaluation Committee

Vice Chair Pating stated that the Evaluation Committee has been working on the Evaluation Master Plan and the oversight of the current evaluation contract, with emphasis on cleaning up the data. Once that information is gathered, it will be distributed. This process will also build the evaluation system.

d. Financial Oversight Committee

Commissioner Poaster stated that the Financial Oversight Committee benefited from the substantial work done by Commissioners Poat and Wooton last year in terms of a finance report framework. The Commission adopted the framework in November 2012, and it has now been populated with numbers that will be presented to the Commission today.

The activities for the coming year benefit from statutory changes related to the Revenue and Expenditure Report (RER) and the Annual Updates, which should provide financial information on a real-time basis. The Committee will be working with staff to utilize this data, and use or create a process in which entities with financial oversight responsibilities coordinate to determine what real financial oversight is occurring.

One of the general arenas of MHSOAC is financial oversight and while it is not tasked with audit and review functions, it is tasked with assuring that those functions occur. The Committee will monitor and develop methods based on that process to further its oversight.

Commissioner Poaster added that the report that will be issued by the State Auditor in May, as it relates to the appropriation and spending of the Mental Health Services Act (MHSA) dollars, will act as a benchmark for the Commission's direction.

Commissioner Poat opined that the Annual Report to the Legislature should include a list of the criteria the Commission uses to certify money is spent appropriately.

e. Services Committee

Commissioner Wooton stated that the purpose of the Services Committee is to identify relevant trends and issues regarding MHSA planning and implementation of all MHSA programs and recommend appropriate policies, guidelines, and regulations with regard to MHSA. The committee will form a work group with members from the other committees to work on these.

The Committee hopes to collaborate with the Department of Public Health (DPH) to talk to stakeholders around the state about what they are doing around health and wellbeing. In collaboration with the Evaluation Committee, best practices in quality improvement, including use of evaluation data will be advocated.

In addition to monitoring Health Care Reform and the implementation of Assembly Bill (AB) 109, the Committee will continue to have oversight of the statewide Prevention and Early Intervention (PEI) projects, and ensure that communities and counties have necessary supports to deliver quality MHSA programs, including a technical assistance center.

Public Comment: There was no public comment.

Commissioner Questions and Discussion:

Chair Van Horn asked Commissioner Wooton, if the counties will provide information about the reduction of disparities around the State. Commissioner Wooton answered that the Services Committee will be collaborating with the CLCC and talking with DPH.

Vice Chair Pating added that the California Reducing Disparities Project (CRDP) plan is being collated; Evaluation Committee is waiting for the final report. He recommended the Commission hear the report so it knows what is being requested.

Commissioner Poat commended the CFLC with regard to Activity #6, to research and promote current best practice services that utilize a recovery scale model.

Chair Van Horn asked what progress has been made with the CRDP plan, particularly in establishing a baseline. Commissioner Wooton asked Stacie Hiramoto to answer that question. Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that she did not believe there was specific measurement of the progress towards reducing disparities. There will be a measurement component, but she thought the Evaluation Committee would be looking into that.

Executive Director Gauger stated that the Commission has a contract with the University of California, Davis (UC Davis) to do an evaluation of the impact of MHSA on reducing disparities, which includes developing baseline information.

Commission Nelson stated that his staff has put together timelines for their projects, ending by October, as well as meetings. Commissioner Poat suggested meeting in October, November, and the first week in December, instead of July and August, to give staff and Committees time to do their work.

ACTION: Commissioner Poaster made a motion, seconded by Commissioner Nelson that:

The Commission adopts the 2013 Committee Charters

- Motion carried, 10-0

4. OVERVIEW OF GOVERNOR'S PROPOSED BUDGET FOR FISCAL YEAR 2013-14

Kiyomi Burchill, Assistant Secretary, California Health and Human Services Agency (CHHS), noted that the budget does not have many proposals regarding community mental health. Last year, by contrast, there were a number of budget proposals adopted as part of the fiscal year (FY) 2012/13 budget on community mental health, which included the reorganization of the Department of Mental Health (DMH), clarifications of MHSA, and the realignment of the Medi-Cal Specialty Mental Health Program. CHHS, their county partners, MHSOAC, and others continue to implement those changes.

On January 10th, the Governor's Proposed Budget for FY 2013/14 was released. With tough spending cuts enacted over the past two years and new temporary revenues provided with the passage of Proposition 30, the State budget is projected to remain balanced for the foreseeable future. The budget creates long-term fiscal stability by aligning expenditures with revenues, paying down debt, and creating a $1 billion reserve.

Health Care Reform

California has been a leader on Health Care Reform (HCR) and implementation, including the early establishment of a Health Benefit Exchange, which is now called Covered California, as well as the early expansion to adults through the Bridge to Reform Waiver. To expand health insurance coverage through the Affordable Care Act (ACA), it provides for two expansions of Medicaid: a mandatory expansion and an optional expansion.

The Mandatory Expansion

Due to a number of factors, including the requirement that most individuals obtain coverage as well as eligibility enrollment simplifications and marketing and outreach activities, enrollment in the current Medi-Cal program will increase. The governor's budget includes a $350 million General Fund to begin to pay for this federally-required expansion.

The Optional Expansion

In addition to the mandatory expansion, states have an elective option under federal HCR to expand coverage for medically indigent adults with incomes up to 138% of the federal poverty level. The federal government promises to provide 100% of funding for much, but not all, of the costs associated with this expansion in the short-term. States will bear a portion of the expansion costs on a permanent basis. The budget outlines two approaches: a state-based approach, and a county-based approach. Each approach has its own strengths and challenges, risks and benefits. Under the current system, counties provide health care to medically indigent adults using a combination of their own and State 1991 Realignment funds.

A State-Based Approach

A state-based Medicaid expansion would build upon the existing state-administered Medicaid program and managed care delivery system. The State would offer a standardized statewide benefit package comparable to what is available today in Medi-Cal but would exclude long-term care coverage. This option would require discussion with the counties about the appropriate state and local relationship, the funding and delivery of health care, and what additional responsibilities the counties would have if the State assumes the majority of health care costs.

A County-Based Approach

A county-based approach would build upon the existing Low Income Health Program (LIHP) and/or indigent health care services. Under a county-operated Medicaid expansion, the counties would act as the fiscal and operational entity responsible for that expansion, which would require approval of waivers of specified requirements.

Medicaid Expansion and Realignment

The Department of Health Care Services (DHCS) continues to plan for the mental health and substance use needs of the expansion population. In March 2012, DHCS submitted a mental health and substance use systems needs assessment to the Centers for Medicare and Medicaid Services (CMS). In April 2013, DHCS plans to submit the next of these requirements: a mental health and substance use service system plan. This service system plan is intended to provide a high-level overview of how California plans to meet the requirements of the benchmark plan and how to ensure effective implementation.

The budget also proposes to reorganize the Department of Alcohol and Drug Programs (ADP). As part of FY 12/2013 budget, the Legislature revised the Administration's proposal, but authorized the transfer of programs and functions of ADP to departments within CHHS in July 2013 instead of July 2012. This year the budget proposes the transfer of all substance use disorder programs from ADP to DHCS.

There are a number of benefits to this reorganization, including the alignment of California with many of CHHS's federal and county partners. Over 30 states and more than 50 of the 58 California counties have community mental health and substance use disorders in one department. By having these along with physical health in DHCS, it promotes opportunities for the improvement of health care delivery and coordination of health care.

This proposal also preserves substance use disorder licensing and certification together in one department. Similarly, the governor's budget proposes to transfer the licensing function that had transferred from DMH to the Department of Social Services on to DHCS to further consolidate licensing and certification for community mental.

At DHCS, the deputy director for Mental Health and Substance Use Disorders Services (MHSUDS) will provide State leadership for both community mental health and substance use disorders. This is the position by statute that is appointed by the governor and confirmed by the Senate to ensure there is a visible leader subject to a transparent confirmation process. There was extensive stakeholder outreach in developing this proposal by three large stakeholder meetings and two rounds of legislative staff meetings in September and October 2012. These helped form a detailed transition plan to CHHS, released on January 10th with the governor's budget. DHCS and DPH, to which these programs are proposed to transfer, have committed to maintain existing stakeholder advisory groups currently with ADP.

MHSA Revenues

Carla Casteneda, Principal Program Budget Analyst, California Department of Finance, stated that the funding for the Mental Health Services Fund is located in DHCS budget, which is listed in the governor's budget under budget detail 4260. For FY 2011/12, the revenues received were approximately $1.2 billion. For FY 2012/13, it has been approximately $1.4 billion. For FY 2013/14, it is estimated at approximately $1.2 billion. This differs slightly from the cash balances, due to the lag in the receipt of the annual adjustment.

Commissioner Questions and Discussion:

Chair Van Horn stated that Vanessa Baird needs to be confirmed by the Senate as deputy director of MHSUDS at DHCS, and asked if the mental health and the drug and alcohol deputies need confirmation. Ms. Burchill answered that the only position subject to confirmation she was aware of is the deputy director position.

Commissioner Nelson asked if there was a reduction on monthly cash receipts. Ms. Casteneda affirmed that there is a reduction of about $200 million FY 2012/13 and FY 2013/14.

Commissioner Carrion asked if there is a timeline regarding the state and county models. Ms. Burchill answered that the models are required by the Constitution to be in place for FY 2013/14.

Commissioner Brown asked if the Problem Gambling Program replaced the program that was funded through the Special Distribution Fund. Ms. Burchill answered that the Problem Gambling Program is funded through the Indian Gaming Special Distribution Fund. The funding will continue to come from the Americans with Disabilities Act (ADA) Gaming Special Distribution Fund. The placement of that program is proposed to transfer from ADP to DPH July 1, 2013, after which ADP will be eliminated.

Commissioner Wooton asked, regarding the continued stakeholder input groups for DHCS and DPH, if there will be smaller advisory committees in those departments. Ms. Burchill answered that there are several advisory bodies, specific to different aspects of the programs of the department, identified in the

transition plan. Commissioner Wooton asked that an advisory committee for mental health and alcohol and substance abuse be considered as well.

Commissioner Nelson asked if anything has been done to unify Medi-Cal requirements across counties to simplify transfers. Ms. Burchill answered that there are eligibility and enrollment simplifications that will be in place for HCR, which will simplify the process.

Vice Chair Pating stated that a Medi-Cal essential health benefit on parity with what was put into the commercial side is still necessary. The Commission has concerns about people who are between private and public insurance. He is thankful for DHCS decision of keeping the substance use services in one department. Now the issue is to integrate mental health, substance abuse, and primary care with HCR. He also emphasized Commissioner Wooton's suggestion of continuing the advisory group.

Commissioner Poaster stated that, from a county perspective, last year mainly involved organization and process. The governor's budget for this year has huge implications for community mental health services through HCR.

Vice Chair Pating asked for an overview of the process and timeline of that decision, and whether it will be in the budget revision process or part of a legislative packet. Ms. Burchill answered that the governor's budget outlined the two approaches, state-based and county-based, and Administration is beginning to discuss both options with interested parties. She was unable to provide a timeline.

Chair Van Horn asked what the input process will be, even though the Legislature will ultimately make the decision. Ms. Burchill answered that discussions are beginning but did not have any specifics beyond that.

5. ADOPT 2013 MENTAL HEALTH SERVICES ACT FINANCIAL REPORT

Commissioner Poaster, Chair, Financial Oversight Committee, stated that one of the responsibilities of the Financial Oversight Committee is the development and monitoring of the financial report. This is the first time the Commission has had the opportunity to look at the revised framework populated with numbers and is being brought before the Commission for acceptance.

Kevin Hoffman, MHSOAC Deputy Executive Director, walked through the PowerePoint presentation which included a chart representing the role of major funding sources in community mental health, broken down by the State General Fund, Realignments 1 and 2, the federal financial participation, and Proposition 63 funds. Of note on the chart was the end of the State General Fund in FY 2010/11 as a community mental health funding source. However, even with the fluctuations in individual accounts, funding for the overall system has grown since the enactment of MHSA and has stayed relatively stable. It is notable that MHSA allocations to counties in the first six months have totaled over $803 million. Simple projections indicate that if that pattern continues, allocations could surpass the Governor's proposed budget amount of $1.3 billion. This is based on tax revenues, so if the revenues are higher, there could be more money in the system than in the governor's projection.

Mr. Hoffman showed several charts representing revenue received at the state level that also takes into consideration two year annual adjustment's lag, and the way money used to go out to the counties based on component allocations. Under current law, the counties receive monthly distributions.

Counties receive allotments from the State Controller's Office (SCO) and must allocate by component according to statute. The Committee plans to change this graph to show component allocations going out monthly from SCO, which reports these on a regular basis.

Mr. Hoffman next displayed a chart representing the state-administered funds by department that shows how much money each received from the Administrative Fund. The Department of Finance indicated there are some minor changes to this; Mr. Hoffman will work with Ms. Casteneda to make those changes.

Chair Van Horn asked where this is in relation to the 3.5% maximum for State administration. Ms. Casteneda answered that the 3.5% for FY 2013/14 budget would be approximately $41.4 million. The difference in this chart, which shows a total of $49 million, is primarily $10 million in the Office of Statewide Health Planning and Development (OSHPD) budget. The proposal is therefore about $40.1 million of $41.4 million. She clarified that the $10 million in the OSHPD budget is not part of the 3.5% cap, but of the Mental Health Loan Assumption Program funded by Proposition 63.

Chair Van Horn asked what the dollars going toward State Operations are used for. Mr. Hoffman answered with assumption that these dollars are intended for staff and other costs.

Commissioner Poaster suggested that learning what those dollars are being used for be an activity added to the Financial Oversight Committee Charter for this coming year. He added that this chart is also intended to remind Commissioners that $15 million a year for four years to CRDP is included in this dollar amount.

Mr. Hoffman showed a chart representing the MHSA Housing Program. He is working with DHCS to update the information on this chart. Vice Chair Pating asked if any unspent money is sitting at the county or state level. Commissioner Poaster answered that it sits at the county level, because it was assigned to the counties.

Vice Chair Pating asked if housing projects are continuing at their previous pace, or if they had slowed down. Commissioner Poat answered that this will be directly affected by the elimination of redevelopment. He suggested the Commission consider how to keep affordable housing moving forward, as it leveraged other dollars. Mr. Hoffman suggested asking California Housing Finance Agency (CalFHA) to do a presentation for the Commission.

Commissioner Nelson asked whether the leveraged amount is specifically for people with mental illness or if they include projects with integrated living situations. Mr. Hoffman answered that it is integrated and added that in a January 7th news article, there was a report card on mental health in the United States, and the National Alliance on Mental Illness (NAMI) called California's Permanent Supportive Housing Program for the mentally ill the Gold Standard, because it provides patients with a safe, structured place to live.

Commissioner Lowenthal added that the Assembly is putting together a work group to look at how to go forward after redevelopment's demise, which will be a good opportunity to examine how supportive housing can factor in.

Mr. Hoffman showed a slide containing points from the governor's budget on key fiscal indicators. One of the main points not listed on this slide is that, for the first time in a long time, there is a balanced budget. Although there are no major changes to mental health funding as in previous years, it must be acknowledged that the ongoing implementation of ACA on mental health will require a broader discussion about the future of the state-county relationship.

Mr. Hoffman stated that the next group of eight charts combine information from annual RERs starting from FY 2006/07. In the early years, most of the expenditures were going to Community Services and Supports (CSS). As the years progressed, Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and other expenditures increased. The tracking of these numbers is constantly assessed for quality improvement. The Annual update Instructions to the counties have been clarified several times to achieve better results regarding how the system tracks these expenditures and their revenues.

Commissioner Poat added that the next stage of the reports will evaluate information on the ARER by the standard adopted by the Committee.

Commissioner Poaster added that this is part of the Charter of the Financial Oversight Committee and will provide an agreed-upon set of definitions for reporting to the Commission on an ongoing basis.

Public Comment:

Stacie Hiramoto, Director, REMHDCO, commended the staff and leadership of the Committee for these charts. She stated that REMHDCO will be interested to see the state-administered fund chart when the analysis or inquiries are done. As a member of the statewide advocacy and stakeholder community, REMHDCO saw the negative effects of the cut in State administration funding from 5% to 3.5% in certain departments.

Molly Brassil, California Mental Health Directors Association (CMHDA), stated that she wanted to clarify that the remaining funds in MHSA Housing Program are with the CalHFA at the state level. Small counties continue to have challenges with the program in terms of being able to access funds from CalHFA for a variety of reasons, including that some of the administrative requirements have not worked well for them. CMHDA invites MHSOAC to look into the MHSA Housing Program

Sandra Marley, consumer and advocate, stated that while the last group of charts with the PEI and INN is very helpful, the last charted FY is 2010 and the funds that were assigned to CalMHSA are therefore missing. Some counties assigned all of their PEI funds to CalMHSA while other counties assigned only some and kept the rest in their county. She stated that she would like to see those figures. Chair Van Horn stated that CalMHSA information will be in the next report.

Steve Leoni, consumer and advocate, stated that he noted in Appendix 3B, the State Administrative Funds, that, in the current FY, the maximum end of the 3.5% cap is $46.9, with $37.4 being budgeted, which leaves about $9.5 million that was not budgeted. He stated that the California Mental Health Planning Council (CMHPC) is in need of money. For example, there were discussions about how to put CMHPC meetings on the telephone, but they do not have the money for the equipment.

ACTION: Commissioner Poat made a motion, seconded by Commissioner Wooton, that:

The Commission accepts the 2013 MHSA Financial Report as presented by the Menal Health Financial Oversight Committee.

- Motion carried, 10-0

6. GENERAL PUBLIC COMMENT

No General Public Comment

7. EVALUATION MASTER PLAN

Vice Chairman Pating, Chair of the Evaluation Committee, stated that the Evaluation Master Plan was conceptualized two years ago by Commissioner Poaster and Chair Van Horn. He thanked Joan Meisel, Ph.D., and Renay Bradley, Ph.D., the MHSOAC staff member in charge of evaluation.

Dr. Bradley asked Commissioners to focus on three policy areas for discussion at the end of the presentation so staff can prepare recommendations based on Commissioner feedback and present a more specific action plan during the second read at the March meeting.

a. The Paradigm for the Evaluation Master Plan chart on page 7 is the conceptual background that will drive all of the evaluations.

b. The Priority-Setting Process on page 38 is the criteria on which Dr. Meisel proposes the Commission base its prioritization. This priority-setting process will enable the Commission to move forward and make yearly determinations of how the Commission will spend funds and time. It provides a foundation on how the Commission will move forward into the future.

c. The Evaluation Master Plan Activities table on page 12 is a list of high and medium priorities for the next three to five years. Accomplishing these goals depends on finances and internal staffing.

First Read – Evaluation Master Plan

Dr. Meisel stated that evaluation is a core activity for MHSOAC, for both its accountability and quality improvement functions. She conducted over 40 interviews, visited four counties, and took a cursory look at national activity in several states to get a sense of what is going on around the country. She showed a slide of several themes of information gathered that she previously presented to the Commission, which pointed out that many evaluation products are not well used. She cautioned against not doing anything with information gathered from evaluations. For the work the Commission has done, what were the implications of those studies? What kinds of recommendations were made? She noted she has suggested throughout the Master Plan that more effort needs to be made towards using both the Commission's evaluation products and the evaluation products of other organizations for accountability and, in particular, quality improvement.

Dr. Meisel discussed the overall model and emphasized that the Master Plan is not for the whole system, only for the MHSOAC. It does not answer everyone's questions. The Master Plan focuses on the Commission's primary audience, which are state-level policy makers and the public. The Master Plan builds off three evaluation principles MHSOAC has previously articulated in a number of documents:

evaluation should be continuous and should proceed incrementally; results must be understandable and useful; and stakeholders must be involved in all stages.

Dr. Meisel discussed PowerPoint slide 8,, "Paradigm for Evaluation Master Plan," which outlines what she thinks are the inputs and outcomes of the MHSA. She listed several inputs from MHSA: for instance, stakeholder planning processes, values and principles, and this Commission were all built off the existing system. All of those inputs were supposed to transform the mental health system, the service system, and the infrastructure. Those changes in the system were supposed to drive improvements for the people being served, such as in functional outcomes, quality of life, clinical status, and a reduction in negative outcomes in the general community.

She discussed the scope of the Master Plan. The Master Plan focuses on but cannot be limited to, MHSA. The changes that have come about through MHSA have implications for the whole system. Moreover, this Commission has the statutory responsibility to look at the adults' and children's systems of care as well. It is inevitable that any assessment that is made of the mental health system is going to be of the entire mental health system and not just MHSA.

Dr. Meisel showed a chart of examples of basic evaluation questions, such as whether the local planning process has been effective or not, whether there have been any changes in the mental health system as a result of MHSA, and whether the prevalence of mental illness has been reduced. Each evaluation activity in the Evaluation Master Plan begins with an evaluation question.

Understanding evaluation methods is critical to being able to use the information. She organized the evaluation activity under three basic evaluation methods: Performance Monitoring System, Evaluation Studies, and Developmental and Exploratory Work Efforts.

Evaluation Method 1: The Performance Monitoring System. This method measures and monitors indicators, which can be a process or an outcome characteristic of a population or system. It is generally measured over time, but the results can also be compared on these indicators across entities. An indicator example is the percentage of new clients from underserved racial and ethnic groups. Tracking an indicator over time shows whether the system is effective in terms of its outreach activities, it raises questions and concerns, and can be used to identify group performers.

Evaluation Method 2: The Evaluation Studies. This method is what is more traditionally called evaluation, or looking at the results of a particular effort or intervention. It can be looking at the results of a program, an element of a program, a process, an initiative, or a value. The better specified the intervention, the more useful the evaluation results will be. Evidence-based practices are established through evaluation studies. An example of an evaluation study is to determine the effectiveness of various ways of engaging transitional-aged youth.

Evaluation Method 3: The Developmental and Exploratory Work Efforts. This method is used in response to a question that will help in either designing a future evaluation study or identifying and developing indicators. It is preparatory and exploratory and does not fit into any of the other categories. An example is exploring the feasibility of developing a meaningful and useful way to categorize Full Service Partnerships (FSP). She stated that members of the Evaluation Committee did not feel like they were supporting evaluation, but developmental activities. They were supporting the betterment of the data

system or answering questions like this, but it is an important part of the evaluation process to include this kind of activity.

Dr. Meisel discussed priority setting. The Master Plan includes two levels of priority, high and medium, which are used to suggest an order of the activities in the Plan. She prioritized based on two sets of criteria: one set of criteria for the evaluation questions that the evaluation activity was designed to address, and another set of criteria for the actual evaluation activity itself.

The criteria for the evaluation questions were: are they consistent with MHSA, do they have a potential for quality improvement, are they important to stakeholders, are there possible partners, are they relevant to the changing environment, and do they address any particular challenges for the system?

The criteria for the characteristics of the evaluation activity itself were feasibility, cost, timeliness, and leveraging.

The Performance Monitoring System, Evaluation Method 1, is used extensively in the health care field, such as the National Committee for Quality Assurance (NCQA), the Healthcare Effectiveness Data Information Set (HEDIS), and the National Quality Forum (NQF). It is important to note that behavioral health indicators were not included in these initial health care systems.

MHSOAC initially measured twelve priority indicators. The majority of the indicators gave reasonably accurate and useful information. Five indicators, particularly those measuring individual level outcomes, lacked clear data definitions, completeness, and timeliness in reporting. The continuing expectations are that all indicators should include breakdowns by demographic characteristics and continue to use county-level data. Dr. Meisel suggested taking a measured, cautious approach to adding new indicators in order to ensure that credibility of the system is established before expanding.

She recommended going over the twelve priority indicators to make sure those work or, if there are different measurement strategies needed, to make the indicators more meaningful. She recommended developing a process for adding new indicators. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Specialty Mental Health Services, is shepherding an effort to look at outcomes. The community indicators use a different methodology. They are population-based and based on surveys, so Dr. Meisel broke it out as a separate category because it is a different kind of data source and information. She also recommended incorporating additional general indicators, and adding indicators that measure change over time with individual clients.

MHSOAC has used the Evaluation Studies, Evaluation Method 2, previously, such as in early studies on PEI outcomes and FSP costs and cost offset studies. MHSOAC also has current evaluation studies, such as looking at three clusters of early intervention programs, a participatory evaluation of the local community planning process, and evaluation of efforts to reduce disparities. Dr. Meisel recommended several high and medium priority evaluation studies for MHSOAC's consideration.

MHSOAC has done Developmental and Exploratory Work Efforts, Evaluation Method 3, such as compiling trend reports and assessing adult mental health needs in California. Dr. Meisel recommended several high and medium priority developmental and exploratory work efforts for MHSOAC's consideration.

Dr. Meisel discussed component considerations. Many outcomes in the performance monitoring system are outcomes of the whole system, which includes PEI, the infrastructure, and the mental health services supported by MHSA. While MHSA is an integrated system, the Commission is responsible for the oversight of the specific components. The Master Plan lists each of these components in context, refers back to evaluation activities in the Plan relevant to that component, and suggests additional actions relevant to that component.

Dr. Meisel stated that there is a lot of work going on in the PEI area. Prior work of MHSOAC for PEI includes the Trends Report, a Summary Evaluation and Data Elements, and the RAND PEI Evaluation Framework. Current work includes the contract with UCLA for an early intervention evaluation, RAND's multi-year evaluation, and CRDP.

There are parts of the Master Plan that relate to PEI, as well as other actions specific to PEI, such as to urge DPH to fund evaluation for CRDP projects. There is a three-year funding cycle, and there are planning workgroups that know the area that can help with the evaluations. After PEI program information is categorized, it can be put into the annual update process for routine collection. A separate PEI framework is unnecessary.

Evaluation is at the core of MHSA Innovation. It is important to understand that the goal is an evaluation of the success of a particular strategy for introducing change into the system. Is it used elsewhere in that county? Is it used in other counties? That is the real test of INN component, whether it is a useful, effective strategy for introducing innovation into the system. The Commission can also support counties to successfully disseminate the results of evaluations done with INN projects and add questions to the Annual Updates, such as: have they done an INN program? Was it successful? How and to whom have the counties disseminated the results? Have counties adopted an INN project from another county?

Technological needs are one of the major ways that MHSA has had an impact. Improved evaluation systems improve evaluation. Dr. Meisel felt collaboration with the California External Quality Review Organization (CAEQRO) would be particularly useful here. They do an extensive site visit to each county every year and have experience with information systems. With the Master Plan, the Commission will develop a plan to identify and track technological need expenditures, determine how they fit into the overall information systems, and identify the impact this has had on the delivery system. There is also a separate section in technological needs regarding county efforts to enhance family empowerment using technology, which is important to include.

WET activity was transferred to OSHPD, but MHSOAC still has an ongoing responsibility to track what is happening. The Advisory Committee is in the process of developing a second Five - Year Plan, which will include a review of what is going on with WET activities so far. In terms of other actions specific to WET, besides obtaining routine updates from OSHPD, is to ensure they include evaluation of county-level activity in their review, as they seem to be focused on only State programs.

Dr. Meisel addressed overarching evaluation issues. It is important to devote more attention to disseminating the results of evaluations and using that information to make suggestions and recommendations. Dr. Meisel emphasized the importance of continuing to address the data system

limitations. The Commission can suggest DHCS do a feasibility study of the different ways to create a new system, but the existing systems must be maintained in the meantime.

Involving stakeholders more in evaluation efforts builds constituency for evaluation work. No one has subject matter expertise in all of the issues that will be studied, so using subject matter experts is important. There are strong people on MHSOAC Evaluation Committee and she encouraged increased efforts to use them.

Regarding the timing and resources of the Evaluation Master Plan, this is an ambitious agenda. If the Commission were to start everything in it over a four-year period, it would have to start two or three new evaluation studies and two new developmental and exploratory work efforts a year, plus the ongoing commitment to all the steps involved in the Performance Monitoring System. Because these projects extend over more than just one year, the Commission can have ten active evaluation projects plus performance monitoring during the course of a year.

The speed with which the evaluation activities are implemented is a function of internal staff resources and the amount of funds available for contracts. In addition to the evaluation activities outlined in the Plan, she suggested coordinating with the Evaluation Committee and with other organizations. The current funding for the contracts supports two or three new contracts a year. Dr. Meisel encouraged the Commission to keep the internal staff resources and the amount of contract funds in balance to avoid any waste.

Commissioner Questions:

Commissioner Poat opined that the adoption of a timeframe is essential, since the Commission's decisions must meld with the state decision-making process. Current resources are allocated in a way that clearly inhibits the Commission from following the Master Plan. He suggested the Commission learn how the support dollars for MHSA are allocated within the departments. The Commission will have data needs that require additional funding.

Commissioner Lowenthal asked what the federal government expects for the Commission as far as whether it must align evaluation with the federal level or not.

Dr. Meisel answered that her understanding is that the only federal requirement in terms of evaluation is the National Outcomes Monitoring System (NOMS). Since every state receives federal grant money, each state must annually submit information regarding outcomes. Some of the California report comes from the Client Services Information System, including data such as demographics and expenditures. Ohio has one of the most robust evaluation departments as part of their mental health system. While this was scaled back due to fiscal constraints, they limited their indicators to those required by the federal government under NOMS. The Consumer Perception Survey is another part of that system, but its data is unreliable and subject to interpretation by each state. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency that is trying to institute some benchmarks in California. As long as mental health services are separate, it makes sense to continue to collect information about behavioral health.

Vice Chair Pating stated that, since CAEQRO for the Medi-Cal population and CMHPC for the Federal Block Grant also have federal mandates for mental health information, the Commission would benefit from coordinating with these organizations.

Commissioner Poat encouraged the Commission to engage the National Academy of Sciences which worked with the California Institute for Regenerative Medicine (CIRM) to develop because of their experience in evaluation techniques. He opined that with their assistance, the Commission can develop a model, evaluate what happens in terms of performance management, and have a national and even international effect with the establishment of standards, models, and programs.

Next Steps:

Dr. Bradley stated that the Paradigm sets the foundation and serves as guidance. She asked Commissioners to refer back to the Paradigm for Evaluation Master Plan chart on page 7 and asked if they felt this chart included everything and structured appropriately. She requested feedback regarding the questions of separating out different sections, or focusing on support indicators.

Vice Chair Pating asked the Commission to consider whether this level of inputs and outputs as a big picture meets the Commission's expectations.

Dr. Bradley added, for clarification, that the Inputs column indicates everything in MHSA health system, including processes, values, regulations, services, and INN projects. The Outcomes column includes what is happening in MHSA health system. The Commission will evaluate the three levels of outcomes: the mental health system, individuals served, and the community.

Vice Chair Pating cautioned that focuses might change because of Health Reform. For example, the Services Committee made a cursory placeholder for measurement of access parity in its integrative policy paper. While it does not fall under MHSA proper, these might be areas for future growth.

Dr. Bradley agreed that there is a contextual component to the selection criteria, regarding focus. On page 12 of the Master Plan, in the "Evaluation Master Plan Activities" table, Dr. Meisel outlined current high and medium priorities, which can be used to reevaluate and reprioritize activities.

Chair Van Horn stated that, as the Commission moves into ACA implementation in the next year, there may be other activities than those listed on the Activities table on page 12. Vice Chair Pating added that Dr. Bradley will be explaining how the list of current priorities on page 12 is interconnected with the priority-setting process on page 38. These two lists comprise the process that will make this a living plan as opposed to a single point in time, because they allow the Commission to add new priorities and access current ones.

Dr. Bradley stated that the Paradigm chart on page 7 and the priority-setting process on page 38 are a foundation that can be revised and added to over time. These two facets detail what the Commission should be focusing on so Commissioners will feel confident in its direction. The Paradigm chart and the priority-setting process were used to generate the Evaluation Master Plan Activities table on pages 12 and 13, and will be used for this purpose on a continual basis.

Commissioner Poat stated that he would move adoption of this report because it is on point at the high conceptual level, and added that he would like to see a staff report for the meeting in March that brings the Activities chart on page 12 to a more operational or work plan conceptualization. Vice Chair Pating stated that it is good to know that Commissioners support the Plan, however, this was a first read only and will not be adopted until the March 2013 Commission Meeting.

Commissioner Nelson, referring to the Individuals Being Served section under Outcomes in the Paradigm chart, stated that "social connectedness" in the lay community means friends, dances, or drop-in centers. It does not mean the support they get from family, because families, once reconnected, tend to give different, and important, types of support than social connectedness until they get into the upper levels of recovery.

He requested changing "Social Connectedness" to "Social and Family Connectedness." He stated that it is important to indicate that this Commission is looking for counties to support consumers and family members and to have this information go out first. Without that support mechanism, there is a significantly larger number of failures. Chair Van Horn agreed that family connectedness is an important individual outcome that helps continue wellness and recovery. Commissioner Lowenthal added that, by having it written, agencies will understand that this is the obligation.

Public Comment:

Michael Reiter, Director, CAEQRO, a project of APS Healthcare, stated that the Plan provides a good framework to bring together the parties who are working on outcomes and monitoring. He added that he wanted to share about required monitoring in response to Commissioner Lowenthal's earlier question. CAEQRO has a contract with DHCS. It was previously with DMH and has been in existence since 2004. CAEQRO looks at Medicaid programs, Specialty Mental Health Programs in particular, in California. He stated that the CAEQRO does site visits to counties and reviews data and technology of all mental health plans. All reports are posted on the CAEQRO webpage, which has a fair amount of data and addresses a lot of issues, including some disparities.

There are two other agencies in Sacramento that need to have an EQRO, a contract with DHCS, by federal standards: the Center for Healthcare Policy and Research (CHPR) Program and the Knox-Keen Managed Care Programs. Their EQROs are very different in that the plans send data as indicators that certain kinds of measures have been met, and then EQROs validate the data. As Dr. Meisel highlighted, the data does not exist within the county mental health plans to do that, so the data that is on CAEQRO webpage is claims data. Finally, there is another kind of external quality review in California for Medicare. The organization that reviews that is a quality improvement organization, which is the same organization that deals with the other EQROs in California, excluding the CAEQRO.

In terms of indicators, Mr. Reiter encouraged Commissioners to first look at required indicators. Dr. Meisel referred to the National Quality Forum (NQF), which makes recommendations to CMS. Mr. Reiter expected the final reading of what the required indicators will be from CMS at the end of February. He added that CAEQRO would like to be invited back to make a presentation in the future.

Jim Gilmer, California MHSA Multicultural Coalition (CMMC), REMHDCO, and the African American Strategic Plan Workgroup, stated that much of the Commission's current work aligns with the goals of CMMC. CMMC had a great emphasis on participatory evaluation, and hopes to work with this Commission in policy development, including a focus on reducing racial and ethnic disparities.

Mr. Leoni stated that the November 15, 2013 Commission minutes incorrectly state that he represented the Menal Health Association in California. He wanted to correct the record. Mr. Leoni stated that he feels Dr. Meisel really listens, which is something a consumer values. The Plan is very ambitious, as it should be, but it needs good funding. He emphasized the need to know more about what the counties are doing, not only for the purposes of leveraging and working with, but to find out how much money, at both the local and state levels, is being spent on evaluation for MHSA in order to compare that with accepted benchmarks for this kind of endeavor.

Commissioner Discussion:

Commissioner Wooton referred to a phrase in the Evaluation Master Plan Activities table on pages 12 and 13, Study 6: "determine effectiveness of consumer run services." She requested changing that to "determine effectiveness of consumer run/led services." Additionally, as the Commission moves forward in the evaluation process, she asked Commissioners to consider that there is a large pool of consumers

and family members who are trained evaluators garnering experience working on oversight reviews and with EQRO.

Vice Chair Pating summarized that Commissioners have agreed in principle with the basic infrastructure, the schema, keeping this a living document, making sure that there is priority setting, and Commissioner Poat's suggestions around the high, medium, and low priorities and coming up with an action plan.

Vice Chair Pating referred to the Overall Model and Scope section on page 27, and asked for Commissioner comments. Commissioners were in agreement with pages 27 and 28 of the Evaluation Master Plan.

Vice Chair Pating referred to the Evaluation Master Plan Activities on page 12, and asked for Commissioner comments. Commissioners were in agreement with pages 12 and 13 of the Evaluation Master Plan. Vice Chair Pating added that, due to Commissioner consensus, Commissioner Poat was right when he asked staff to move forward with this list, putting together a work plan, the first set of Master Plan recommendations, and a timetable of what the next steps might be.

Commissioner Poat suggested that sister state agencies will need to be notified that this is going on, even before Commissioners sign off on it, to see if they think it appropriate to start organizing around some of these questions. It is important that supporting stakeholders agree. Commissioner Poat added that he envisions some sort of discussion process so that Commissioners will know that the Agency, the Department of Finance, the Legislature, and other stakeholders are together on this.

Chair Van Horn granted an exception to Retired Commissioner Vega to make a comment during Commission discussion time.

Eduardo Vega, Executive Director, Mental Health Association of San Francisco and President of the California Association of Mental Health Peer Run Organizations, stated that he is excited about the Evaluation Master Plan, particularly about the systems indicators. He added that the Commission can improve on consumer-run programs and other empowerment systems-level measures. He suggested considering the level of consumer empowerment within individual programs or agencies; to what degree local policy bodies include people with lived experience; and how much it has moved from a system entirely driven by clinicians and professionals to one in which consumers of the services are integrated into leadership, program, and policy roles throughout the state.

Chair Van Horn added to Commission Poat's guidance to staff to prepare an action plan that implements the activities outlined on page 12 for the March meeting, by asking Dr. Bradley to prepare an implementation calendar.

Executive Director Gauger stated that she wanted to ensure that Commissioners are not setting up artificial expectations for the March meeting. The Master Plan was written for the Commission to set priorities for the next three to five years and for other resources it may obtain. As staff prepares an implementation plan, there are different cut off points. One is a plan for right now, which includes Dr. Bradley and a budget of $875,000. Other stipulations are that the Commission will acquire additional resources. When Dr. Bradley prepares a plan to bring back in March, it will have those different stipulations.

Executive Director Gauger added that she is in regular contact with Assistant Secretary Burchill. The statute charged Agency with leading this effort even though the Commission already had it underway, so some of the decisions will be Ms. Burchill's in terms of what she might think about her other departments, OSHPD and DHCS, becoming involved now or focus on EPSDT outcomes. Executive Director Gauger added that she also is in regular contact with Diane Van Maren in the Pro Tem's Office.

Vice Chair Pating thanked Dr. Meisel for her excellent work. Chair Van Horn added that this has been a superb example of how a consulting contract is carried through to engage Commissioners and internal staff, to the point where there is potential for serious transformation in evaluation.

8. CALIFORNIA INSTITUTE FOR MENTAL HEALTH PRESENTATION ON CURRENT PROJECTS INCLUDING BEST PRACTICES, COUNTY COLLABORATIVES, AND RESOURCE CLEARINGHOUSES

Vice Chair Pating stated that the Services Committee, as part of MHSOAC Logic Model, has been actively researching how to build a technical assistance (TA) center to share information with the state, counties, and stakeholders. MHSOAC has had presentations on developing evaluation studies and bringing in data, but the findings of these studies must be shared for the job to be fully done.

This presentation is the first information gathering on current TA centers for Commissioners to consider what is being done, the feasibility of MHSOAC involvement, and whether there are any gaps or a need for further TA in California.

Autumn Valerio, Program Coordinator, California Institute of Mental Health (CiMH), stated that CiMH has had three contracts with the former DMH providing TA on MHSA activities. CiMH will present two of their initiatives today: clearinghouses and learning collaborative models.

Ms. Valerio stated that CiMH has three websites developed in partnership with MHSOAC and DMH staff to highlight the work that has been done with MHSA: a site dedicated to PEI, a site dedicated to INN, and a disparities clearinghouse site focusing on achieving health equity and reducing disparities.

The first website, launched in 2010, is the PEI Clearinghouse site. The process of developing the website structure included working closely with MHSOAC staff, DMH program managers, and county PEI coordinators, who provided input on the kinds of resources that would be useful for PEI program planning, implementation, and evaluation. The site will provide general information to the public, to be a resource to counties as they plan and implement PEI programs, to provide TA, and to provide an opportunity for shared learning through community forums. The website is www.mhsapei.org.

The second website, launched in 2011, is the INN Clearinghouse site. The process of developing the website structure included working closely with MHSOAC and DMH staff who provided input on the kinds of resources that would be useful for INN program planning, implementation, and evaluation. The site will provide general information to the public, to be a resource to counties as they plan and implement INN programs, to provide TA, and to provide an opportunity for shared learning through community forums. The website is www.mhsainn.org.

The third website, launched in 2012, is the Health Equity Clearinghouse site. The process of developing the website structure included working closely with community stakeholders, who provided input on the kinds of resources that would help reduce disparities and increase health equity. Through blogs and interactive social media,, the site will provide general information to the public, TA to implementers, and an opportunity for shared learning through community forums. The website is www.cahealthequity.org.

Doretha Williams-Fournoy, Deputy Director, CiMH, gave a presentation on CiMH mental health and substance use disorders (MHSUDS) and primary care integration collaboratives. Upon the adoption of ACA and the mandate to integrate primary care and behavioral health, it was evident that the public

mental health system was not ready to implement this type of transformation. It would take years to implement a change of this nature without a process that would assist in learning and enacting the needed changes. CiMH embarked upon a process of investigating integrated service systems around the world. They consulted with a variety of experts with experience in improving systems of care and identifying the competencies needed to migrate into the goals of the triple aim of ACA: improved health outcomes through the provision of better care at a reduced cost.

The challenge at CiMH is that the current California system has to respond to the needs of a population of people that is not only diverse in race and ethnicity, but also in lifestyle, economics, geography, education, access to care, and level of need. In 2014, there will be a new influx of individuals who have not previously had access to care, but will bring with them additional demands upon a system that is already struggling to meet the need.

A system is required that works across disciplines and services sectors of the community to improve the health of California's safety net. Given these challenges, CiMH, as a TA organization, asked how they could support the improvement efforts of counties and their mental health and behavioral health providers to implement this change.

Ms. Williams-Fournoy stated that people with mental health and substance use problems also experience issues related to health care. In order to create an effective system of care that can respond to a wide variety of needs, an alliance between primary care, mental health, substance use services, and the community must be forged. Current services are poorly coordinated across these entities. The goal of the CiMH learning collaboratives is to help these entities develop strategies for communicating, implementing changes, and adopting innovations in care that will promote better outcomes, including self-management for consumers and clients.

The Model for Improvement is a quality improvement theory and utilizes methods used to apply to a problem. The Breakthrough Series is a learning collaborative process that uses the improvement in care coordination, and supported through a learning collaborative model. While both of these models are used in primary care and on a national and international level, they have not been used in a public mental health system in California prior to CiMH's use.

The Model for Improvement provides a script for how to identify and test small changes within a system of care or within an organization. It involves answering the following questions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement? The next step is to initiate a series of small changes – the plan, do, study, act (PDSA) cycle – that will affect the outcome.

The Breakthrough Series Model includes a convening of experts from each discipline, including consumers and family members, community-based organizations, providers from primary care, mental health and substance use, county administrators, and innovators in the field, who work together in teams to identify the possible changes that can be made to attain a variety of goals. At the end of the year, the teams collect and disseminate the learning that has occurred and make plans for the next level to be addressed.

There are four current CiMH learning collaboratives: the Advancing Recovery Practices (ARP), the Small County Care Integration (SCCI), the Care Integration Collaborative (CIC), and the Strategies for Integrating Health, Prevention, and Community (SIHPC).

The ARP focuses on mental health providers as high-performing specialty partners, and increasing organization capacity and client flow through advancing recovery. ARP has 15 teams, which include organizations and counties

The SCCI was initiated at the request of small counties to address their needs around integration. It focuses on paving the way to integration and bi-directional care through improved communication, coordination, and collaboration with primary care. Eleven small counties are part of this collaborative.

The CIC is a pilot project that began this year and has five county teams made up of mental health, substance use disorders (SUD), and primary care providers. This collaborative is expected to spread next year and invites additional teams as well.

The SIHPC is a collaborative developing effective partnerships between community health centers and community organizations. It is a PEI collaborative between Dignity Health Foundation and CiMH. Dignity provided funding up to $600,000 for five teams to participate in the development of strategies for incorporating community-based organizations into the primary care continuum of that community. It also includes coordinating services and promoting PEI and self-management strategies in communities.

Health Reform requires care coordination, and all of these collaboratives focus on this. Individuals with complex needs often require services from a variety of sources in order to address their needs. Current systems are funded separately, and have different eligibility requirements and target populations. Many individuals with the greatest health risks and costs have co-occurring disorders. Treatment for multiple conditions is siloed and often not evidence-based. Additionally, care is not coordinated. Screening, referral, treatment, and monitoring for mental health or SUD is not routine. Screening for physical health conditions is not routine in specialty mental health and SUD programs. Care coordination includes the deliberate organization of client and patient care activities between two or more participants involved in a client's or patient's care to facilitate the appropriate delivery of health care services.

The goal of the learning collaboratives is to implement the ACA triple aim, which will result in better health for populations, better care for individuals, and reduced costs through improvement. There will be a Triple Aim Summit in Burlingame on May 23-24, 2013. It will include panels focusing on specific aspects of the triple aim. Target populations to be included in this summit are counties, primary care, health plans, substance use services, and SAMHSA and CMS-funded pilots. CiMH is inviting national experts with a relationship between care coordination and integrated care and the ACA triple aim. Subjects addressed at the summit are stigma reduction and health equity, the new role of health plans, and the emerging and key role of peers.

Commissioner Questions and Discussion:

Vice Chair Pating suggested adding a Proposition 63 logo to the website. He asked if the content is managed, and whether there is a possibility of adding live assistance. Ms. Valerio stated that CiMH actively manages the sites, but there is currently no live chat.

Vice Chair Pating stated that the possibilities to share MHSOAC evaluation information or findings range from websites to interactive clearinghouses, conferences, and collaborative learning. He stated that a targeted plan regarding what MHSOAC needs to communicate is required. Vice Chair Pating stated that the Services Committee's vision was first oriented towards providing resources for counties and providers. SAMHSA websites can be used as a model.

Commissioner Poat stated that he was interested in learning the results of the Triple Aim Summit and hoped the Commission can be part of it. He stated that the Commission is headed toward being able to lead a review of the data that comes out of these processes to replicate successes and modify areas for improvement. He referred to the 'Behavioral Health Problems are Rarely the Only Health Problem' chart, and, while this issue is often discussed, he appreciated that Ms. Valerio was able to assign numbers to it.

Chair Van Horn recommended adding a telephone number to the websites. Ms. Williams-Fournoy replied that there is room for a strategy used by people who do not have access to the Internet. There is not a resource like that available at this point, but she invited more conversation about how to go about addressing that need more specifically.

Chair Van Horn asked how CiMH funded these activities. Ms. Williams-Fournoy answered the funds come from a MHSA TA grant from DHCS.

Commissioner Brown asked if there are resources for anger management, thoughts of violence, or homicidal thoughts on the websites, as these are key areas for PEI. Ms. Valerio answered that they do not at this time, but if that is an area of need, they can expand the focus and look into that. Vice Chair Pating added that Commissioners might want to consult with MHSOAC staff to see what they have learned from MHSOAC media campaign as well.

Commissioner Nelson asked about the traffic on the websites per day. Ms. Valerio answered that they are unable to track that directly for PEI and INN websites, but the Health Equity website has a social media component and can track the number of people who visit the Facebook page, Twitter, and Youtube videos.

Commissioner Nelson asked how these websites are marketed. Ms. Valerio answered that the PEI and INN sites were marketed for counties, so the county coordinators know of the sites. CiMH is still putting together a marketing strategy for the Health Equity site.

Commissioner Nelson asked if there are consumer and family scholarships to the summit. Ms. Williams-Fournoy answered that there are.

Vice Chair Pating asked what the next steps would be. Executive Director Gauger answered that one of the things she would like to explore with staff, and possibly Dr. Naylor-Goodwin of CiMH, is whether an opportunity for Commission and CiMH staff to collaborate on a clearinghouse exists. At the end of

February, the MHSOAC Proposition 63 website is scheduled to go live. There are opportunities to link the Proposition 63 website with some of CiMH clearinghouse information, and opportunities to share in training and TA. The statutes have strengthened the role that the Commission plays in those areas. MHSOAC does not have dedicated staff available for training and TA, but maybe some Commission staff can be available to answer phone calls from the Proposition 63 website. It is a resource issue for both CiMH and MHSOAC, but there are opportunities for the two websites to link to each other for the resources of both entities to be available to answer questions from consumers and stakeholders.

9. COMMISSIONER COMMENTS

Commissioner Poat stated that, on page 1 of section 5 of the Evaluation Master Plan, there are 55 evaluation deliverables with an additional 39 deliverables underway. He suggested a discussion in the March meeting on how these 39 deliverables would play into the timeframe. Executive Director Gauger stated that the 39 deliverables underway are a resource issue for Dr. Bradley. Staff has to monitor them and ensure each deliverable complies with the contract. Consideration must be given to how that workload and the timing of the deliverables factor into the new efforts that have been charged.

Commissioner Poat stated that he is also interested in what can be learned from those 39 deliverables and how to apply those lessons. Executive Director Gauger stated that Dr. Meisel has considered this. One of the policy frameworks that the Commission has adopted is to build on existing evaluations and to learn from them. Vice Chair Pating suggested reviewing the evaluation calendar for the year in the March meeting.

Commissioner Nelson suggested having a discussion on the possibility of adding some type of visual aid for the PowerPoint slides in meetings, for members of the public who are unable to attend MHSOAC meetings in person. Jose Oseguera of MHSOAC staff stated that staff is looking at the possibility of having a camera focused on the slides for people to link into on the Internet. He stated that there is also a possibility of adding sound.

Commissioner Wooton suggested asking OSHPD to do a presentation for the Commission, specifically around the peer certification.

10. GENERAL PUBLIC COMMENT

Ms. Marley stated that she has attended MHSOAC meetings since 2005 and has seen many great changes. There are articles about how MHSA has succeeded and how Proposition 63 is a model, since voters voted in Proposition 63 to have MHSOAC and DMH before they went into practice. She stated that those are being violated. It is becoming so complex; there are so many additional associations; there are so many layers that transparency is being lost. She asked where the stakeholder fits in. California has 58 counties, which means a possible 200 different Boards of Supervisors' opinions. Where are they getting the expertise to have opinions and make decisions? Where are the mental health departments in the counties? What is their expertise for handling or making the evaluations? There is a big population not served by MHSA, so where does that fall in with Democracy and parity?

George Fry stated that Calaveras County invites people who do not have computers to come to the Behavioral Health Center and sit in on the Webinars. He asked the Commission to share that information

with other counties. He stated that he appreciated Commissioner Brown's questions and asked the Commission to spend more time focusing on those kinds of projects.

11. ADJOURNMENT

There being no further business, the meeting was adjourned at 3:12 p.m.