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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting
August 22, 2024
9:00 AM – 2:30 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

August 22, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on August 22, 2024, at 9:00 a.m.

This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123, 11123.5, and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE	August 22, 2024
TIME	9:00 a.m.
LOCATION	6401 Linda Vista Rd, San Diego, CA 92111 and Virtual

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Wendy Carrillo, *Assemblymember*
Steve Carnevale
Rayshell Chambers
Shuonan Chen
Dave Cortese, *Senator*
Dave Gordon
Gladys Mitchell
James L. Robinson III, Psy.D., MBA
Alfred Rowlett

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link: https://mhsoac-ca-gov.zoom.us/meeting/register/tZArduysrDkrHtaxhqA3ns8l5Kz1_5voqBV

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

- Champion vision into action to increase public understanding of services that address unmet mental health needs.
- Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.
- Inspire innovation and learning to close the gap between what can be done and what must be done.
- Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. Items may be considered in any order at the discretion of the Chair. Public comment is taken on each agenda item. Unlisted items will not be considered.

9:00 a.m. **1. Call to Order and Roll Call**
Information

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

9:05 a.m. **2. Announcements and Updates**
Information

Chair Mara Madrigal-Weiss, Commissioners, and staff will make announcements and give updates.

9:30 a.m. **3. General Public Comment**
Information

General Public Comment is reserved for items not listed on the agenda. No discussion or action will take place.

9:50 a.m. **4. July 25, 2024 Meeting Minutes**
Action

The Commission will consider approval of the minutes from the July 25, 2024 Commission meeting.

- Public Comment
- Vote

10:00 a.m. **5. Consent Calendar - Innovation**
Action

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

1. Orange County: Psychiatric Advanced Directives (PADs) Phase Two
2. Orange County: Community Planning Process Extension

- Public Comment
- Vote

10:10 a.m. **6. Full-Service Partnership Funding Allocation**

Action

The Commission will hear a proposal to allocate $20 million in Mental Health Wellness Act funding to strengthen California's Full-Service Partnership programs; *presented by Melissa Mollard-Martin, PhD. Chief, Research and Evaluation*

- Public Comment
- Vote

11:20 a.m. **7. Mental Health Student Services Act Report**

Action

The Commission will hear an overview of its work to support school mental health, including an update on a legislatively mandated report on the implementation of the Mental Health Student Services Act (MHSSA), results of the recent MHSSA Request for Applications, a report out on Commission supported MHSSA Technical Assistance Teams and the potential for new investments in supporting school mental health. The presentation will include local MHSSA grant partners and students who will share information on their elementary school program, Hope Squad; *presented by Melissa Mollard-Martin, PhD. Chief, Research and Evaluation and Riann Kopchak, Chief, Community Engagement and Grants*

- Public Comment
- Vote

12:45 p.m. **8. Lunch**

1:30 p.m. **9. Proposition 1 Implementation Follow-Up**

Action

The Commission will hear an update on items related to implementation of Proposition 1, with emphasis on reforms that impact the Commission and its operations; *presented by Kendra Zoller, Legislative Deputy Director*

- Public Comment
- Vote

2:30 p.m. **10. Adjournment**

Our Commitment to Transparency

In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 calendar days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance, whenever possible.

Notes for Participation

For Public Comments: Prior to making your comments, please state your name for the record and identify any group or organization you represent.

Register to attend for free here:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZArduysrDkrHtaxhqA3ns8l5Kz1_5voqBV_

Email Us: You can also submit public comment to the Commission by emailing us at publiccomment@mhsoac.ca.gov. Emailed public comments submitted at least 72 hours prior to the Commission meeting will be shared with Commissioners at the upcoming meeting. Public comment submitted less than 72 hours prior to the Commission meeting will be shared with Commissioners at a future meeting. Please note that public comments submitted to this email address will not receive a written response from the Commission. **Emailing public comments is not intended to replace the public comment period held during each Commission Meeting and in no way precludes a person from also providing public comments during the meetings.**

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding public participation procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fail, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public have a right to offer comment at the Commission's public meeting. The Chair will indicate when a portion of the meeting is open for public comment. Any member of the public wishing to comment during public comment periods must do the following:

→ If joining in person. Complete a public comment request card and submit to Commission staff. When it is time for public comment, staff will call your name and you will be invited to the podium to speak. Members of the public should be prepared to complete their comments within 3 minutes or less, unless a different time allotment is needed and announced by the Chair.

→ If joining by call-in, press *9 on the phone. Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

→ If joining by computer, press the raise hand icon on the control bar. Pressing the raise hand will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line, announce your name, and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

In accordance with California Government Code § 11125.7(c)(1), members of the public who utilize a translator or other translating technology will be given at least twice the allotted time to speak during a Public Comment period.

AGENDA ITEM 4

Action

August 22, 2024 Commission Meeting

July 25, 2024 Meeting Minutes

Summary:
The Mental Health Services Oversight and Accountability Commission will review the minutes from the July 25, 2024 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) July 25, 2024 Minutes; (2) July 25, 2024 Motions Summary

Handouts: None

Proposed Motion: That the Commission approves the July 25, 2024 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date July 25, 2024

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, M.A., Vice Chair*
Mark Bontrager, J.D., M.S.W.
Sheriff Bill Brown
Steve Carnevale
Rayshell Chambers, M.P.A.
Itai Danovitch, M.D., M.B.A.*
David Gordon, Ed.M.
Jay Robinson, Psy.D., M.B.A.
Alfred Rowlett, M.B.A., M.S.W.

*Participated remotely

Members Absent:

Keyondria Bunch, Ph.D.
Assembly Member Carrillo, M.A.
Shuo Chen
Senator Dave Cortese, J.D.
Gladys Mitchell, M.S.W.

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Sandra Gallardo, Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Riann Kopchak, Chief, Community Engagement and Grants
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:03 a.m. and welcomed everyone. The meeting was on Zoom, via teleconference, and held at the MHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Madrigal-Weiss stated the Commission's Strategic Plan for 2024-27 was approved at the January Commission meeting. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending In-Person: Chair Madrigal-Weiss, Commissioner Bontrager, Commissioner Brown, Commissioner Carnevale, Commissioner Chambers, Commissioner Gordon, Commissioner Robinson and Commissioner Rowlett. Attending Remotely: Vice Char Alvarez and Commissioner Danovitch.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Commission Meetings

- The May 2024 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on August 22nd at 9:00 a.m. in San Diego, California.

National Minority Mental Health Month

July is National Minority Mental Health month. Culture, ethnicity, and race play a role in the way that each person experiences the world. These factors, among others, have profound effects on mental health, especially for Black, Indigenous, and people of color. Not everyone has equal and equitable access to these crucial services because of stigma, shame, or fear of judgment. These factors create significant barriers that prevent individuals from seeking mental health care.

Chair Madrigal-Weiss thanked Commissioners, Commission staff, and community members for elevating the voices of those who have been historically marginalized, ensuring that no one is left behind. A future where mental health is a priority for all can be created through education, advocacy, and community support and empowerment.

Disability Pride Month

The Governor has issued a proclamation declaring July 2024 "Disability Pride Month." With this proclamation, California joins communities around the nation in recognizing July as an opportunity to celebrate the many ways that people living with disabilities add

to the diversity and strength of the state. Diversity, equity, inclusion, and accessibility are integral parts of the Commission's ongoing work.

Revenue Stability Workgroup

As part of Proposition 1, the state has established a Revenue Stability Workgroup. Jointly led by the California Health and Human Services Agency (CalHHS or Agency) and the Department of Health Care Services (DHCS), the workgroup will develop solutions to address revenue volatility and support the sustainability of county behavioral health programs. The workgroup begins today and will submit its recommendations to the Legislature and Governor by June 30, 2025.

Chair Madrigal-Weiss appointed Executive Director Ewing to represent the Commission on the Revenue Stability Workgroup. Commissioners who are interested in participating in the workgroup are to contact staff.

Golden Gate Bridge Suicide Deterrent

The Commission was invited to the Golden Gate Bridge Suicide Deterrent Commemoration on Monday, July 15th. This event is a celebration of a long-awaited suicide barrier, built to reduce the number of deaths resulting from jumping off San Francisco's Golden Gate Bridge. The Commission provided seed funding for this project in 2017, with additional funding from other state agencies and federal and local partners.

This project is the culmination of a tireless campaign by families who lost loved ones at this iconic site. As of January 1, 2024, the net now runs the full 1.7-mile span of the bridge and has already saved many lives. The Commission is proud to be a part of this project.

Suicide Prevention

The Commission was invited by the California Legislative Native American Caucus to participate in a roundtable with tribal leaders and community members, along with officials from California's Office of Suicide Prevention, to discuss the critical issue of suicide within tribal communities.

Behavioral Health Innovation

Proposition 1 modified the design of California's behavioral health innovation strategy. Beginning in 2025, the Commission will receive $20 million each year, for a minimum of five years, to invest directly in behavioral health innovation. Commissioner Carnevale has been exploring opportunities to strengthen behavioral health innovation. He led a site visit to UC Berkeley in June and was accompanied by Commissioners Bontrager, Chambers, and Robinson. This site visit included a tour of the CRISPR lab where Jennifer Doudna, Berkeley's Chair of Biomedical and Health Sciences, conducted her groundbreaking work in DNA modification, as well as a visit to UC Berkeley's SkyDeck and Venture Lab incubator programs to support innovation. The Commission has been invited back to UC Berkeley this fall for a roundtable to continue the conversation with Chancellor Richard Lyons and other UC representatives.

Building off its work on innovation, prevention, and community engagement, the Commission was invited to send four representatives to London to engage with UK

behavioral health leaders. Chair Madrigal-Weiss, Commissioners Carnevale and Brown, and Executive Director Ewing met with UK leaders to explore shared learning opportunities on innovation, education, safety, public/private partnerships, data analytics, outcome-based contracting, and more.

Chair Madrigal-Weiss asked Commissioner Carnevale to share about learnings, next steps, and additional opportunities being explored to meet with the United Nations and the Clinton Global Initiative in New York in September, UK partners in October, and the Organization for Economic Cooperation and Development in Rome in November.

Commissioner Carnevale stated Proposition 1 highlights opportunities for public/private partnerships to increase innovation in behavioral health. He stated the Chair asked him to explore opportunities for the Commission in innovation over this past year to better respond to the state's shifting innovation for mental health. The private sector is currently investing tens of billions of dollars in behavioral innovations, but much of that will likely expand the gap between the individuals the Commission focuses on.

Commissioner Carnevale stated government alone cannot solve these problems. A key part of this work is uplifting capital innovation to dramatically increase the amount of private capital that can supplement the public sector investments and improve outcomes. He stated, in his discussion with the Governor and his leadership team, it was clear that the Commission has an opportunity to focus behavioral health innovations on addressing disparities. Private sector partners are willing to make that happen. This is what he has been exploring.

Commissioner Carnevale stated one challenge is not knowing how best to work with government because government is complex. The Commission is uniquely positioned to address the opportunity to facilitate solutions for groups – such as clients, family members, providers, public officials, educators, law enforcement, business, labor, research, and others – to come together and collaborate to serve those who need it the most. The Commission is well-positioned to facilitate that public/private partnership that can improve outcomes for people and the system, particularly around prevention and early intervention.

Commissioner Carnevale stated California is gaining international recognition for the work it has done and what is possible to come next. This was seen during the Commission's recent trip to London. He stated appreciation for the support of the Commission in facilitating conversations with potential partners who can help drive transformational change.

Commissioner Carnevale stated, toward those innovation goals, he organized the following events last month:

- The Commission visited UC Berkeley, including the CRISPR lab, to explore how to harness capacity for gene editing from this famous research university to turn their attention to behavioral health. Chancellor Richard Lyons offered to partner with the Commission to explore all opportunities. Much of what was seen at the site visit was funded with private dollars relating to start-up funding, grants, and others.

- The Commission's London delegation participated in a knowledge exchange with over 30 behavioral health leaders from across England and Europe in partnership with the British National Health System and were asked to join several global knowledge exchange partnerships with Australia, New Zealand, and other countries to share collective learning. The delegation met with leaders from the European Investment Bank Welcome Trust, which is one of the largest philanthropic foundations in the world. They have platforms addressing behavioral health inequities.
- The Commission's London delegation met with leaders in neuroscience, innovation, public/private partnerships, and research on the impacts of improving behavioral health outcomes, and with the leaders from the Institute of Health Metrics and Evaluation (IHME), which was built with a $1 billion investment from the Gates Foundation, to bring data, analytics, and evaluation to help shape health care decisions.
- The Commission's London delegation met with the Institute of Government Outcomes at Oxford University to learn how they do things differently to support outcome-based decision making in a range of public programs across the UK.
- The Commission's London delegation met with local leaders and their nonprofit partners who are also pushing the edge in outcome-based contracting where providers are paid a unit rate for outcomes. This is an interesting model that can shape how the Commission might invest Mental Health Wellness Act funds for Full-Service Partnerships (FSPs).

Commissioner Carnevale provided the following recommendations:

- Host a webinar with the British Institute for Government Outcomes to learn more about their models and how they can be applied to California.
- Expand the capacity for impact-focused research in California that can be an opportunity for university partnerships.
- Engage with the UK to learn more about their people-based partnerships that leverage outcome-based funding to focus providers who develop tailored solutions to care that are driven by individual needs. This can be powerful.
- Implement the model seen that could be part of the FSP-light opportunity that has been discussed many times in California over the past 10 to 15 years.
- Visit the IHME, which is based in the University of Washington, or invite them to California to share the Commission's work that would be key to informing the state's new mandate to improve the investment in prevention and early intervention and the data systems needed to support that work.

Commissioner Carnevale shared upcoming opportunities nationally and abroad to continue the conversation on strategies for public/private partnership to focus on reducing disparities. He recognized the work of Commission staff to support these opportunities that grow community engagement and strengthen grant making, research, evaluation, and policy.

Commissioner Brown thanked Commissioner Carnevale for his work in organizing the delegation and the trip. It was an enlightening, productive, and rewarding experience, both for the delegates and for British colleagues. There was a tremendous interest in what the Commission is doing because it is very different from what they are doing in many ways. They have dedicated and committed mental health professionals working with long-term and, in many cases, significant programs but they are far more siloed than California. They do not have the same kinds of collaborative efforts and cross-disciplinary engagement that California is blessed to have.

Commissioner Brown stated the UK, Scandinavia, and other countries are doing a better job in terms of the proactive Healthy Brain Initiative and support for the whole concept of the healthy brain with financial professionals who want to see significant investment made in the Healthy Brain Initiative.

Commissioner Brown stated he took copies of the Commission's *Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness* report, which focuses on collaboration, combined budgets, and more. He stated he noticed as he was handing them out that the November 2017 publishing date of the report was prominently featured on the cover. Many of the programs that are highlighted in the report were in their infancy. He suggested updating the report and republishing it. That, coupled with the Suicide Prevention and the upcoming Firearms Reports, would be of benefit not only in California and across the nation but around the world.

Commissioner Brown stated Chair Madrigal-Weiss, Commissioner Carnevale, and Executive Director Ewing were extraordinary ambassadors for the work being done in California. They were polished in their presentations and discussions. The delegation was well received and have been asked to return. There is an opportunity for the Commission to embrace the UK as great partners to help each other in this endeavor.

Chair Madrigal-Weiss asked staff to work on bringing the Criminal Justice Report up to date. She agreed that there was a lot of learning and sharing during the trip to the UK. She stated she brought up the fact that she is proud of the reports created by the Commission. She stated she shared the Prevention and Early Intervention and Suicide Reports. They have similar data and findings to what are contained in the Prevention and Early Intervention Report, especially around communities of color. She noted that there is diversity in the UK and in London and yet the representatives did not reflect their population. The importance of the student voice for student mental health is not yet to the degree that the Commission advocates for it.

Chair Madrigal-Weiss stated one of the concepts the delegation brought up was about doing things with those impacted versus doing things to, for, or at them. They were pleased to see the collaboration and wondered how it works. Law enforcement, schools, and business were represented in the three Commission delegates. They wondered about the representation of the other Commissioners. She stated the delegation talked about the richness in diversity and how this level of collaboration did not happen overnight. The delegation talked about wanting to break up the school-to-prison pipeline and other rich learning conversations.

Chair Madrigal-Weiss stated the UN meeting talked about brain health as a natural resource. It behooves investing in brain health because the richness of the people is the

natural resource. The UK and the delegates continue to share resources and ask questions of each other. She stated she was proud to be a part of the delegation. The Commission is starting to inform other groups nationally and internationally and learn from them.

Commissioner Chambers stated she is encouraged by the work and leadership of the delegation. She suggested including providers on the ground to add to this conversation and connect the pieces. She stated it is important to have public/private partnerships and to bring community-based organizations in to share insights and lessons learned.

Commissioner Robinson acknowledged Commissioner Carnevale and his leadership. The trip to UC Berkeley, seeing the cutting-edge technology, and thinking about that being applied to solve behavioral health issues was amazing.

New Staff

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

- Norma Pate, Deputy Director of Administration and Performance Management, introduced Charles Lee, the new Information and Security Officer, as part of the IT team.
- Riann Kopchak, Chief, Community Engagement and Grants, introduced Katie McKenzie, the new Plan Review and Technical Assistance Provider, as part of the Program Operations team; Kendal Vargas, the new Associate Governmental Program Analyst, as part of the Community Engagement and Grants team; and Sarah Webber, the new Associate Governmental Program Analyst, as part of the Community Engagement and Grants team who will also work on community engagement, logistics, and support.
- Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation, introduced Meredith Parrington, Summer Behavioral Health Fellow supporting the student mental health efforts and youth advocacy.
- Executive Director Ewing introduced Lilah Gonsalves, Summer Behavioral Health Fellow. Both Summer Behavioral Health Fellows will help develop a more formal process to recruit youth.
- On behalf of the Commission, Chair Madrigal-Weiss welcomed Charles Lee, Katie McKenzie, Kendal Vargas, Sarah Webber, Meredith Parrington, and Lilah Gonsalves to the Commission.

Executive Director Performance Evaluation

The Executive Director performance evaluation is scheduled to take place during closed session at the October Commission meeting. Chair Madrigal-Weiss directed Chief Counsel Gallardo to conduct three anonymous surveys utilizing Survey Monkey for a 360-degree evaluation, as part of that evaluation process. The three cohorts to be surveyed are Commissioners, Commission full-time staff, and key external contacts. Results are to be presented at the October Commission meeting during closed session.

Subpoena

On July 18, 2024, the Commission, along with five additional state departments and agencies, was served a document request subpoena from Meta/Facebook relating to the State of California versus Meta/Facebook case over social media's harm to youth mental health. This is a routine subpoena. The Attorney General will be representing the Commission in this matter. Chair Madrigal-Weiss formally requested that all Commissioners preserve all documents, including electronic communications, relating to youth behavioral health. Chief Counsel Gallardo will keep the Commission updated on the progress of the subpoena.

3: General Public Comment

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, asked everyone to read Welfare and Institutions Code 5604.2 and thanked the Commission for what it does. The speaker discussed silo-breaking in California. Silos break when conversations happen. There is not much two-way discussion going on in California due to transparency, access, and safety for individuals to speak publicly in meetings, even for individuals to acknowledge what their relationships are by putting their names and associations in public view so everyone can see who is attending meetings. It is difficult to see this happen.

Steve McNally stated they have not seen much action in the Commission to look upward and downward or to ensure that implementation of aspirational programming is smooth, effective, and known. The speaker stated concern that communities will again be left wondering where the right door is for meetings developing the regulations of Proposition 1. While it is transparent online, there is a lot of promotion outside of eList of what is going on. The speaker stated concern that a small group of people know a lot and a large group of people, the system users, know very little. The journey in systems that do not document well, whether good or bad, defines the entire system.

Steve McNally urged the Commission to tighten up its relationship with the California Behavioral Health Planning Council and local behavioral health boards by attending local meetings, getting geographically connected across the state to help bring families back to communities.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of Steve McNally's comments. The speaker stated they made public comment at the last Commission meeting recommending that the Commission form an Innovations Committee to advise and help with the Commission's increased responsibility outlined in Proposition 1. REMHDCO recommends that an Innovations Committee be formed as soon as possible so the public can give input into the parameters of the Innovations Partnership Fund.

Stacie Hiramoto stated the presentation slides for today's agenda item on Proposition 1 implementation did not contain information on how community input will be collected. Although Proposition 1 did not have the emphasis or specificity on behavioral health policies and programs being consumer-, family-, and community-driven that was so explicit in Proposition 63, this value is also a best practice. REMHDCO hopes that the Commission will provide opportunities for robust community input on their administration

of the Proposition 1 components, not only on innovation partnership but on all areas of responsibility. The speaker asked the Commission not to design policies and procedures internally or only with other government partners and then ask the community for input just before they are finalized.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, spoke in support of Stacie Hiramoto's comments. The speaker stated, given the issues and anxieties on the ground about the Governor's giving permission to clear homeless encampments, the Commission needs to take a voice to ensure that whatever is done is humane and without ignoring the fact that there is no affordable housing. Another issue for concern is that the Community Assistance, Recovery, and Empowerment (CARE) Act is not yet fully rolled out.

Dr. Benhamida stated they were glad the Commission delegation could take a trip to the UK. She asked that the Commission contact an organization like the Muslim American Society – Social Services Foundation for input and possible contacts before future trips.

Rachael Simonoff Wexler, CEO, California OnTrack, stated California OnTrack was recently awarded a $2 million grant in Round 5 of the Children and Youth Behavioral Health Initiative (CYBHI). Award decisions were supposed to be made in December of 2023 but awardees were notified in March of 2024. Only 12 of the 99 awardees are coordinated specialty care (CSC) programs in the Round 5 Grant Program, which was to fund CSC programs for early intervention. Since the March notification, California OnTrack has yet to receive a Subaward Agreement, Notice of Funding, or any movement at all. This means that grantee providers will be unable to initiate their programs to help communities in need across the state. The speaker asked the Commission to fund the 12 CSC Round 5 CYBHI mental health grants that were awarded by the Commission and the DHCS.

Chair Madrigal-Weiss asked staff to look into the Round 5 grant funding.

4: <u>May 23, 2024, Meeting Minutes</u>

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the May 23, 2024, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

There were no questions from Commissioners and no public comment.

<u>Action</u>: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Robinson made a motion, seconded by Commissioner Brown, that:

- *The Commission approves the May 23, 2024, Meeting Minutes, as presented.*

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

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

The following Commissioner abstained: Commissioner Bontrager.

5: Consent Calendar

Chair Madrigal-Weiss stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action. She noted that the documents related to these projects and the staff analyses are included in the meeting materials.

- Innovation: Electronic Health Records Multi-County Collaborative: Sierra County
- Resolution: Workers Compensation Insurance for Volunteers

Chair Madrigal-Weiss stated this month's consent calendar includes the approval of one innovation proposal from Sierra County and a resolution authorizing State of California workers' compensation insurance for Commission volunteers. The innovation proposal is to allow Sierra County to join the Electronic Health Records Multi-County Collaborative for up to $910,906 in Mental Health Services Act) MHSA innovation funds. At the May Commission meeting, Commissioner Rowlett suggested that innovation proposals brought forward to be considered on consent contain information on how the proposal aligns with the Behavioral Health Services Act (BHSA) priorities, sustainability under the new BHSA funding areas, and consideration of the impact of the BHSA to existing programs.

Chair Madrigal-Weiss stated Chief Counsel Gallardo has clarified that under state law, for the Commission to ensure the workers' compensation policy covers Commissioners and other persons who volunteer with the Commission such as committee members, a formal resolution needs to be adopted to that effect. She asked Chief Counsel Gallardo to share details of the resolution.

Chief Counsel Gallardo stated, as a result of the passage of Proposition 1, on January 1, 2025, the number of Commissioners is expected to grow by close to 70 percent to 27 Commissioners. Currently, State of California workers' compensation insurance does not apply to Commissioners or to any other individuals serving the Commission in an unpaid, volunteer capacity, such as serving on Commission committees. She recommended that, with the increased risk presented by the addition of 11 Commissioners, the Commission pass a resolution that would allow unpaid volunteers to the Commission to qualify for State of California workers' compensation insurance for any injuries sustained during the performance of their unpaid, volunteer duties to the Commission. Any increase in cost is estimated to be minimal, if any. California Labor Code section 3363.5(a) requires a public agency or commission to declare by adoption of a formal resolution to have State of California workers' compensation insurance apply to its volunteers.

Commissioner Comments & Questions

Action: Chair Madrigal-Weiss asked for a motion to approve the Consent Calendar. Commissioner Gordon made a motion, seconded by Commissioner Carnevale, that:

The Commission approves the Consent Calendar that includes:

- *Funding for Sierra County to join the Semi-Statewide Enterprise Health Record Multi-County Collaborative Innovation Project for up to $910,906; and*
- *That the Commission adopts the Resolution authorizing workers' compensation insurance coverage for persons providing voluntary services to the Commission without compensation within the meaning of Labor Code 3363.5 and California Government Code 3111.*

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

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

6: State Budget and Expenditure Update

Chair Madrigal-Weiss stated the Commission will hear a presentation on the newly signed state budget for fiscal year (FY) 2025-26 and consider approval of expenditures. She asked staff to present this agenda item.

Deputy Director Pate provided an overview, with a slide presentation, of the enacted California state budget for FY 2024-25, MHSOAC budget overview, current year budget expenditure plan, FY 2024-25 procurements, and expenditure authorization of the 2024-25 budget overview and expenditure plan. She stated this year's budget is significantly less than prior year budgets because the Commission received one-time funds that are spent over multiple years. She noted that funding for the Commission's current initiatives has not been reduced and the Commission continues to implement programs with prior year funds.

Commissioner Comments & Questions

Vice Chair Alvarez stated she appreciated the acknowledgment of the changes with the implementation of the BHSA and the shifts in roles and responsibilities of the Commission. She asked if there is an opportunity in the budget or where there may be opportunities with wiggle room that would allow the Commission to pivot for more community engagement or stronger partnership opportunities. There are many unknowns. She asked about wiggle room for unexpected things that are coming up.

Executive Director Ewing stated there is wiggle room in the budget in several ways. The implementation of Proposition 1 happens over time, which provides the opportunity to engage the Governor's team and the Legislature through the budget process to adjust the Commission's implementation habits to release pressure on the budget. Operationally, in how the funds are distributed between the outgoing dollars for local assistance, the core operational funds like personnel costs, and operational funds have wiggle room. The Commission has discretion in terms of the categories.

Executive Director Ewing stated the Commission is required to spend these dollars consistent with the rationale with which the Commission received them. For example, funds from the MHSA must be used within the MHSA but there is a percentage of discretion within those dollars that allows the Commission to move those dollars around

to address unanticipated or emerging opportunities. That is always done in consultation with the Department of Finance and accounting staff. The Commission has that authority. If members are interested in a deeper dive in understanding where staff is spending dollars or where resources are increased in one area like community engagement, staff would be happy to explore how to do that. Unfortunately, not all information is available since the Commission is waiting for direction from the fiscal departments over the kinds of reductions the Commission may need to take on the operational side.

Commissioner Chambers uplifted the comments made by the Vice Chair. As the Committees have been reconvened, Committee members are ready to roll up their sleeves and do intentional work relative to the implementation of Proposition 1. The theme that has consistently come up is the community engagement piece and finding ways to engage individuals outside of the box to get feedback. She stated she appreciated flexibility in consultation with the Department of Finance, particularly around having wiggle room to do things as they emerge. Committees want to ensure that voice of the community is documented and sent to the Governor and the Legislature.

Commissioner Robinson asked how the decision was made to work with the Public Works Alliance.

Executive Director Ewing stated the Commission has made investments over the last six years to stand up the allcove youth drop-in center. The Commission engages local partners who are involved in that effort. Some are funded directly by the Commission through a competitive grant process and others are funded with county dollars. The Commission facilitates a learning collaborative with each of the local partners to talk with them about challenges they are facing in establishing these centers and implementing a long-term sustainability model looking at workforce, infrastructure, IT, and public understanding. The Commission funds consulting on behalf of these partners. The partners identify the experts that they feel can best meet their need.

Public Comment

There was no public comment.

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve the FY 2024-25 expenditure plan and associated contracts. Vice Chair Alvarez made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves the Fiscal Year 2024-25 expenditure plan and associated contracts.*

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

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

7: Transformational Change in Behavioral Health: Transparency and Accountability

Chair Madrigal-Weiss stated the Commission will hear from a panel of speakers on opportunities for improved accountability and transparency under behavioral health transformation. She asked staff to facilitate this agenda item.

Dr. Martin-Mollard stated the panelists will speak from subject matter expertise and community experience to outline opportunities for strengthening accountability systems for behavioral health. She stated the Commission identified data as a priority during the January 2023 Strategic Plan report out. Staff have worked since then to shape a research and evaluation agenda for the Commission that supports its initiatives and broad portfolio that includes activities such as community engagement, data analytics, conversations with experts in metrics and evaluation frameworks, and landscape analyses of data availability.

Dr. Martin-Mollard stated, with the passage of Proposition 1, there are additional opportunities to support the Governor's bold agenda to transform the behavioral health system and improve outcomes for individuals, families, and communities in California. With tremendous investments and ambitious reforms in behavioral health over the last several years, what is needed now is an overarching Accountability Framework that supports these aims. This Framework should focus on resources, services, and outcomes. Better, smarter decisions can be made about how these limited resources are used when tracking and monitoring the services and supports the systems of care are providing and what outcomes those services are achieving.

Dr. Martin-Mollard thanked the panelists for joining the Commission today to offer their perspectives. She introduced the members of the panel and asked them to give their presentations.

Lishaun Francis

Lishaun Francis, Senior Director of Behavioral Health, Children Now, stated Children Now did a report several years ago on the need for robust data systems for California's child behavioral health. She provided an overview, with a slide presentation, of the purpose, methodology, types of available data, and data limitations. She noted that the report was limited to the past three years. Children Now found that the most-measured metric domains were about system use and early identification, while the least-measured metric domains were about quality and outcomes.

Ms. Francis stated the Children Now report found that there are significant gaps in disaggregated demographic data, a lack of data on non-clinical settings, and no consistent data across delivery systems.

Ms. Francis stated Children Now suggests the following needed changes that the state should focus on when thinking about the data to collect:

- Improve demographic data collection.
- Provide disaggregated data for special populations (i.e., young children, children and youth with child welfare, foster care, and/or juvenile justice involvement).
- Use existing data to prevent and treat trauma.

- Gather consumer experiences and satisfaction.
- Focus on quality.
- Focus on outcomes.

Ms. Francis reviewed a slide of Children Now's suggested new metrics to measure around access, consumer experience, quality, early identification, known prevalence, and outcomes, such as the access measurement of the percent of children ages 0-5 receiving support for an identified developmental or behavioral health challenge, or the consumer experience measurement of the percent of youth who were satisfied with their provider. She noted that this list is not exhaustive.

Stephanie Welch

Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS, stated CalHHS is in the information-gathering phase. She stated she will give a high-level presentation, although she came today to listen and take the questions and comments that she hears back to the Departments. She provided an overview, with a slide presentation, of the BHSA goals to be measured, the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), County Integrated Plan for Behavioral Health Services and Outcomes, County Behavioral Health Outcomes, Accountability, and Transparency Report, and State Auditor Report. She stated the BHSOAC will collaborate with CalHHS to promote transformational change through research, evaluation, and tracking outcomes.

Ms. Welch stated, regarding quality measurements and disparities, CalHHS is legislatively required to establish behavioral health performance and quality metrics in consultation with counties, community partners, and the Commission. This work will begin this September.

Ms. Welch stated CalHHS and the DHCS are moving to a web-based platform. Three-Year County Integrated Plans for Behavioral Health Services and Outcomes will be uploaded into a web-based system. The goal is to provide real-time access to data and to make it easy and accessible to use. She stated the goal to approaching this responsibility this time around, rather than 20 years ago, is to innovate along the way to evolve from an elementary process to a sophisticated process. She stated this is where the Commission can be helpful in terms of learning how to become more innovative. The idea is to identify how to better understand technology and available tools, and take the opportunity to utilize those things. Primary values behind this would be to not require people to collect and record information that will not be used. Outcomes should be reflective of what consumers and family members want to experience, and able to change things more quickly. CalHHS looks forward to the Commission joining them in doing the work.

Ms. Welch suggested attending DHCS listening sessions. The session on Tuesday focuses on substance use disorder (SUD) integration.

Ryan Quist, Ph.D.

Ryan Quist, Ph.D., Behavioral Health Services Director, Sacramento County, and President, County Behavioral Health Directors Association (CBHDA), provided an

overview of the county perspective on the importance of data and accountability for system-level decision-making. He began his presentation by quoting the saying, “We measure what matters.” He noted that everyone can have different perspectives on whether what is currently being measured is what matters. He suggested improving on this.

Dr. Quist stated the BHSA effort presents a unique opportunity to update and improve upon the public transparency of county behavioral health resources. Counties consider themselves stewards of the public dollar and very much want to ensure that community partners have the information they need to better understand what a county does and how it does it. Most importantly, county behavioral health directors have for some time embraced the idea of being held accountable for the outcomes the county produced. The Commission’s analysis of FSP data has shown that existing FSPs significantly reduce justice involvement among enrolled clients. This study was done using existing FSP justice data that proved what counties already knew to be true – that county services change lives.

Dr. Quist stated, in addition, data can be a powerful tool in helping to identify disparities and making meaningful progress on closing those gaps. This is why further disaggregating data where data is available is important. Today, the state collects significant amounts of data related to county behavioral health. Just like managed care plans, counties are held to requirements as it relates to reporting on health data.

Dr. Quist stated the biggest challenge is that data is collected in a way that does not allow for aggregated data to paint a statewide picture. Counties and providers have faithfully reported on their funding and programs in the ways requested and required, but the information sent to the state is not always requested in a way that supports 21st Century data-driven system transparency and accountability or in a way that supports taking action to respond in real-time to make system improvements.

Dr. Quist stated counties are excited about the ideas they are contemplating with the DHCS around a new framework or technology foundation to update how data can be collected and reported. He stated, since joining Sacramento County, it has been one of his goals to make what the county does and how much the county does more accessible to communities so communities have a better understanding of county behavioral health programs, services, and obligations. He noted that this is not an easy feat.

Dr. Quist addressed the challenges presented by current legacy data collection systems and local solutions for quality monitoring, clinical decision-making, and system performance management. He stated an example of a legacy data collection system that undeniably needs to be updated is the FSP Data Collection and Reporting (DCR) system. Currently, the DCR system is a requirement for FSP programs, but this data has little practical use. He stated the need for thoughtful conversations about the DCR system. Sometimes, more is simply more and not better. He spoke against including additional requirements on top of the already complex scaffold of data reporting requirements.

Dr. Quist addressed the need for standardization of metrics and outcomes. He stated standardization is vital to aggregate, disaggregate, and understand impact at the local and state levels. This is important. He provided the following recommendations:

- Ensure the development of metrics that build upon existing data collection requirements and systems where the data is good, such as claims data. More could be mined there.
- Consider where data collection is not serving clients and the public with improved quality and outcomes.
- Ensure that any measures that are aimed at accountability are actionable, meaning that the Commission has the power to move the needle on those indicators with the current funding and services.
- The concept for accountability for actionable measures is not controversial and is a core principle of health data measurement and a core value of the behavioral health system.
- County efforts will be to ensure that, as the new system for accountability and outcomes is built, new burdensome data collection requirements are not placed on counties or contract providers, and that data is collected by the state in a way that supports valid, actionable, and meaningful measures aligned with the state and local priorities.
- The behavioral health workforce crisis is ongoing. The Commission must keep in mind, while working on developing more data collection, that time clinicians spend on data collection is time they are not spending with consumers.

Dr. Quist underscored points made in Ms. Welch's presentation: it is fundamentally important, as the Commission is thinking about developing and providing recommendations around accountability measures and similar initiatives, that there is a deep study of what is already being collected. There are many big things happening now in behavioral health, many of which are on similar topics. He stated the need to ensure that, while developing new data to collect for the BHSA, it is put in the context of the whole system and the whole picture of what is currently impacting behavioral health in the county or else that one more thing will be added on top of everything else. Having a collective unifying vision of that perspective will help reach the goals of being responsive to what communities would like to know and what needs to be reported, which will hold the Commission accountable.

Sergio Aguilar-Gaxiola, M.D., Ph.D.

Sergio Aguilar-Gaxiola, M.D., Ph.D., Founding Director, Center for Reducing Health Disparities (CRHD), UC Davis, stated his presentation will focus on the critical importance of listening, building trust, and creating trustworthiness. Other panel members have discussed the importance of being informed by the local community and listening to people about what matters directly to consumers and their families.

Dr. Aguilar-Gaxiola stated George Santayana, a foremost Hispanic-American philosopher, said "those who cannot remember the past are condemned to repeat it." He stated he has seen the inequities in access to care firsthand for those who most

need behavioral health services. He showed a photo of Daryl Steinberg, Ms. Welch, and himself at a Proposition 63 rally he organized at the Fresno State campus in 2004. He shared the aspirational goals in anticipation of the passage of Proposition 63, the MHSA, in January of 2005, almost 20 years ago.

Dr. Aguilar-Gaxiola stated, if transforming the behavioral health system of care is the goal, then listening, building trust, and creating trustworthiness with those intended to be served are essential. Ralph G. Nichols said “the most basic of all human needs is the need to understand and be understood. The best way to understand is to listen to them.” Dr. Aguilar-Gaxiola stated the critical ingredient in enhancing the mental health of communities through improving care and reducing mental health disparities is meaningful community engagement.

Dr. Aguilar-Gaxiola stated the CRHD’s North Star is to serve underserved communities. He asked Commissioners what their North Star is. He suggested adopting a seeking mode to go where the community is to provide behavioral health services.

Dr. Aguilar-Gaxiola reviewed the National Academy of Medicine’s Advancing Health Equity and Systems Transformation through Community Engagement model and Seven Impact Stories for Assessing Community Engagement that have recently been released. One of the stories was done with Debra Oto-Kent, Founder and Executive Director, Health Education Council, about Weber Park in Roseville and the Walkability Project. He played the four-minute video for the Commission.

Dr. Aguilar-Gaxiola discussed assessment instruments and noted that we cannot change what we do not measure. He stated the National Academy of Medicine released 28 measures of meaningful community engagement least year. Each instrument and its questions are mapped to the conceptual model.

Dr. Aguilar-Gaxiola stated the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Innovation Project in Solano County was funded by the Commission with MHSA innovation funding and provided evidence that it is possible to transform a whole system of care working with people directly in what matters to people. The ICCTM created the ICCTM Learning Collaborative, a one-year training program that has trained 161 individuals to date on community engagement, building trust, and becoming trustworthy.

Dr. Aguilar-Gaxiola stated the main lessons learned were to be sincere, simple, and straightforward, and to “shut up and listen.” He provided the following recommendations:

- CalHHS Behavioral Health should co-create an organization-wide meaningful community engagement framework that effectively engages all Californians and in particular historically underserved communities and has trust and trustworthiness embedded throughout strategic planning, implementation, evaluation, and dissemination.
- Support CalHHS in co-designing a culturally and linguistically appropriate community engagement framework to effectively engage and serve diverse underserved communities.

- Provide training to CalHHS using relevant and culturally responsive resources, and strategies that translate into meaningful community engagement plans.
- Provide technical assistance and training with a focus on listening to communities attentively and actively and on building trust and becoming trustworthy.

Debra Oto-Kent

Debra Oto-Kent, Founder and Executive Director, Health Education Council (HEC), stated 33 years ago, when she founded the HEC, it was known that most health is determined by what happens outside of the doctors' and clinicians' offices. The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Ms. Oto-Kent stated the HEC focuses on five components in its intersection to health in communities: access to resources and services, social connection and mental health, economic well-being, community safety, and wellness education. The foundational strategies of all HEC initiatives are partnership and collaboration, and robust, authentic resident engagement. No one sector can fundamentally improve the health outcomes of communities. Individuals who are closest to issues affecting their communities are also closest to solutions. It is our responsibility to change direction and use what we are hearing from the data to find solutions, look at opportunities, and look at what is already out there. The work often does not take extra funding but takes talking with people to see the opportunities out there to align with what people are asking for. Trust is built through action.

Ms. Oto-Kent shared the story of Nina, her grandmother, the dirty, broken, run-down park across the street, and changing the park into a fun and welcoming place for everyone again.

Ms. Oto-Kent shared the following lessons learned:

- Community engagement is about trust, history, and relationship.
- The messenger, approach, and how to enter and exit a community matters.
- Listen without an agenda; act on what is heard; pivot.
- Meet people where they are: where health happens in communities and neighborhoods.
- Incremental change; offer visible change; show evidence of listening.
- Asset-based and resilience-based data collection.
- People want to contribute and sustain what they help build.

Commissioner Comments & Questions

Chair Madrigal-Weiss read a question from Commissioner Danovitch about substance use integration. She stated he asked how to ensure that adding services is not just talked about but that it also includes integrating into the approach to financing,

workforce development, prevention, accountability, and communication; how to ensure that adding services has deep and vertical integration; and how the Commission can specifically help the DHCS address overcoming obstacles that they anticipate in implementing the plan.

Ms. Welch stated State Medicaid Director Tyler Sadwith, DHCS, can speak to these questions with a greater level of expertise. She stated part of Agency's responsibilities is that it is discussing this across Departments. Internal conversations have been about the opportunity to do more integration, especially around FSPs, to use that model to look at how to integrate care financially, clinically, and through the workforce. She suggested talking about ways the Commission can be involved in some of the workforce strategies that CalHHS is working on. It is important for Commissioners to provide input. She stated the need to figure out how to do that in real-time in a more meaningful way.

Ms. Welch stated SUD integration is in her top five opportunities with Proposition 1. She stated she has heard from counties that they see truly getting to integration and leveraging some of the existing and ongoing work being done in the Medi-Cal space to ensure that SUD and mental health services are integrated. She asked to keep the conversation going.

Commissioner Brown thanked the panel for their presentations and for the work they continue to do. He noted that the video was crisp, to the point, and had great graphics. He asked about the new regulations and why the equity-related data is mandatory for county reporting while carceral and homeless data are optional. This is problematic. Partial responses will not be as meaningful statewide.

Ms. Welch stated there are many reasons. CalHHS is hopeful that, even though it is not mandated, it will become something that everyone does. Those are the kinds of measures that CalHHS will be look at on a statewide basis. She stated, while there are new and important levers at the state level to do accountability, especially in the area of collecting information about resources, there still will be many decisions that will take place at the local level. This is a problem in every community. Counties to a certain extent must focus on their priorities. While it is not mandated, going back to those target populations, people who are justice-impacted and in particular people who are coming home from incarceration are priority populations. She stated she did not know how a county can be held accountable to their priority population if they are not also looking at that data. She stated she expected the communities will select to include it, even though it is not mandated.

Commissioner Brown agreed with Dr. Aguilar-Gaxiola's suggestion to change the "may" to "should" before it is rolled out because the "may" will be seen as optional. He encouraged CalHHS to consider changing the language.

Commissioner Chambers asked about the engagement in the commercial plans for children and families and if children and families are being asked if they are enjoying the services. That is important. She stated she is interested in working with Agency on the community process with Proposition 1 implementation. She asked how to present this information to the community in a way that is equitable and culturally appropriate. She suggested that the Commission be intentional in supporting counties.

Commissioner Chambers stated, to Commissioner Brown's point about engagement, she agreed with meeting individuals where they are. She asked if there is a way to go to the jails to find out what individuals need. She asked to not lose consumers and family members while only thinking of including peers. The people with lived experience know what is happening and how to connect. She stated some of the rhetoric she heard around peer support services during the transformation was about peers doing art groups and sewing classes, but the panel highlighted that the main priority of communities is to gather with each other and connect. These are core things that peer workforce supports. She asked what that will look like in the medical model as part of the transformation.

Commissioner Bontrager spoke in support of transparency and data-driven decision making but stated concern about the implications of it. He gave the metaphor that health care has a "firehose of data." There is a fire and the firehose is laying on the ground and the water is going in the gutter. The firefighters are standing around saying they need more water. This is what it feels like sometimes when it comes to data. This is important because, of the 24 counties he represents in the Medi-Cal Managed Care Plan, many are rural. They do not have the capacity administratively to do many of these things. Every dollar they spend on reporting outcomes is a dollar of resources they do not have to provide a service.

Commissioner Bontrager stated this is not always represented in Sacramento. The Commission talks about diversity, equity, and inclusion (DEI), but one inequity is structural inequality between rural and urban areas. That is real but, as the requirements are increased, he stated he is afraid it will exacerbate the inequities. He stated he sees this with efforts around school engagement, such as the Student Behavioral Health Incentive Program (SBHIP), where some of these schools are literally one-room schoolhouses with school districts of 11 individuals. They cannot avail themselves to some of these resources because they do not have the administrative capacity. He stated the hope that this is kept in mind.

Ms. Welch responded to Commissioners Chambers's and Bontrager's comments. She stated CalHHS has asked more of counties. The state took 2 percent out of the state administrative funds to send it to the counties so they had more resources to do a more robust community planning process and to comply with these reporting requirements. One of the conversations CalHHS had in the workforce space was that this is not just about building clinicians, but about redesigning and supporting systems to be more effective in being an effective managed care plan while living in a system where it is also the community safety net. Data experts are needed, not just clinicians who also have data responsibilities.

Ms. Welch stated transformational change includes supporting county partners to transform into being more effective at what they have been asked to do – capacity around data, administration, and performance improvement, not just a delivery of direct care. CalHHS has a particular eye towards trying to understand how to make everything from exemptions to regional approaches so that rural and smaller counties can have the flexibility that they need to be successful and recognize that they are different, but CalHHS is more globally trying to think about how to do this.

Ms. Welch noted that this does not necessarily speak to Commissioner Bontrager's firehose analogy, which was excellent. She confirmed that these are all themes that will be taken up. She stated she confirmed that the work starts in September. She stated the hope that the Commission will be ready to work with CalHHS on establishing behavioral health performance and quality metrics. She stated she knows it does not help to give individuals more resources to do more stuff. CalHHS is working closely with partners at the California Mental Health Services Authority (CalMHSA) and counties to consider how to do this in a way that also supports small counties and gives them the capacity.

Commissioner Rowlett highlighted the presentations that emphasized the importance of the perspective of the end user because, as a community-based organization providing behavioral health services for almost five decades, if you do not "shut up and listen" to the end user, you do not understand the importance of the disconnect between the key performance indicators or the outcomes desired and how they navigate achieving behavioral health remedies to social determinants of health that are everywhere.

Commissioner Rowlett asked to elevate the information that comes from the Client and Family Leadership Committee (CFLC) and the Cultural and Linguistic Competency Committee (CLCC). There is a perspective that the Commission can glean from the end user, the individuals who are utilizing Medi-Cal to navigate behavioral health and health care. The Commission can better understand that perspective and the challenge there.

Commissioner Rowlett stated there are key performance indicators that Committee members will speak to, especially as it pertains to the utilization of services provided by Medi-Cal Managed Care Plans. He stated State Medicaid Director Tyler Sadwith has stated at a past Commission meeting that managed care plans are highly capitalized and there are expectations associated with that assertion. Having Committee members speak to the implications of that and the benefits associated with being a recipient of services provided by a managed care plan is important and is something that the Commission should listen to. There is an indicator associated with a person's benefit that is being provided by a managed care plan and how that person navigates that benefit; it would be helpful for the Commission to hear how the end user experiences that.

Commissioner Rowlett stated Commissioner Carnevale has talked about artificial intelligence (AI) and how to utilize AI. There are opportunities to enhance the experience of today's behavioral health workforce incorporating AI into the work that is done. He encouraged the Commission to consider that and how they can help as a convener and in other ways to get individuals to talk about the utilization of AI as a solution to documentation – the number one challenge of providers.

Commissioner Rowlett agreed with Dr. Aguilar-Gaxiola for the need to be prepared to "shut up and listen" to individuals and understand that that is not just a colloquialism; it is fundamental in the delivery of these services because individuals will share their needs and those needs are not always what is expected. He stated the hope that it is those kinds of conversations that the Commission can help the Department to have going forward.

Commissioner Carnevale acknowledged that he was impressed with the movement of the words and mindset that is being expressed here, particularly talking about outcomes. He stated, while he appreciates the possibilities, he continues to be frustrated. The business perspective is the least exciting perspective and yet it is foundational to everything. He agreed with Dr. Aguilar-Gaxiola that we cannot change what we do not measure, and with Dr. Quist that legacy data collection systems are antiquated, but the 21st Century has incredible technological opportunities to break down historic barriers in communication. There is much potential there that needs to be taken advantage of because it captures costs that can be deployed to other things.

Commissioner Carnevale stated he did not want to take away from Commissioner comments about community engagement and focusing on the end user because that is critical and is the North Star to all this, but he wanted to elevate, to Commissioner Bontrager's point, that there is this data, this firehose that is disconnected from the fire. The piece that is not elevated is, when talking about data, one cannot only look at data compliance and requirements and needs around the end user; one must also look at the system that is the delivery mechanism. Otherwise, we can measure all this data and discover what we already know, which is that we basically failed at almost every metric, but there is nothing actionable to fix it.

Commissioner Carnevale stated, while measuring what is going on at the patient level, the Commission must be measuring the system. There are no blockages to that. He noted that business struggles with this just like government does. Good businesses figure out ways of measuring employee-, departmental-, and company-level performance. The Commission should be measuring it and creating transparency, and there should be no blockages to reporting it. All work in business shows that, if an organization is run well through those kinds of tools, then the outcomes they are trying to get to will be delivered. However, many times, they do not have the tools to see whether they are pointing the firehose at the fire. He stated he does not see that elevated here. This is a whole other body of work around how the organization is run.

Commissioner Carnevale stated it is not just important to data for mental health, but the Presidential election is literally about this. It is about good government. The research shows that in 1960, most people trusted government, and today the number of people who trust government is in the single digits because they do not understand it, why it is not delivering solutions, or why there is no transparency, and they do not think that government is good. Data is the key to proving that there is good government or that it can be reached. This is not just a discussion about data; it is a discussion about Democracy.

Chair Madrigal-Weiss stated, although there is data on the individuals who are currently accessing the system, there are many others who are not because of the way the system is created. This missing data allows only a partial picture of the need. When the Commission held hearings on legislation that put Proposition 1 on the ballot, communities voiced concerns over and over that the legislation was not going to be informed by community voice. She asked how Agency will ensure that community voice informs implementation and how the Commission can help.

Ms. Welch stated the Commission has a committee structure and a series of community contractors. Agency does policy work in Sacramento and does not have the capacity available for community engagement. She suggested that the Commission host events, write papers, and collect community voice, and Agency will consume everything the Commission and other community partners produce. Agency hosts monthly listening session on topics. She suggested that everyone provide feedback to Agency via their email response box. She suggested that the Commission's community contractors ensure that the voices they represent are informed and prepared for the local process. She stated she is open to ideas about how to bring more community voice to Agency.

Chair Madrigal-Weiss asked Agency to consider the panel recommendations. She suggested supporting best practices in community engagement to put in the guideline document that Agency will publish by the end of the year.

Ms. Welch stated she will share the National Academy of Medicine's 28 measures of meaningful community engagement, mentioned in Dr. Aguilar-Gaxiola's presentation, with the Departments as they begin working on their community engagement processes.

Commissioner Chambers stated she liked the point about utilizing the Commission's community contractors. She gave a call to action to anyone listening to hire the community and the promotoras to engage with community.

Commissioner Gordon stated creating better data, etc., are transaction goals – things that enable something to happen. He asked about outcome-oriented goals, such as improving access to services, focusing on prevention over treatment, and listening to consumers.

Ms. Welch stated statewide goals are being created around quality and efficacy, which is one of the mandated requirements as part of the data and metrics piece. She encouraged the Commission to do that as well since the Commission will already be part of that process, and to share those ideas with CalHHS. She referred to her presentation slide on the BHSOAC and stated she plans to have conversations with leadership around what it means for CalHHS to coordinate with the Commission to promote transformational change through research, evaluation, and tracking outcomes.

Chair Madrigal-Weiss asked staff to work on ideas on how the Commission can support community engagement.

Public Comment

Richard Gallo, Peer Support Specialist, asked the Commission to standardize data collection for FSPs. This should have been done all along to learn about positive outcomes of the FSP program.

Richard Gallo stated Peer Support Specialists need to be part of the FSP mandated requirements. Peer Support Specialists are individuals with lived experience who may also be part of the unhoused, justice involved, or substance use communities who can help maintain or improve recovery.

Richard Gallo suggested contacting Disability Works California, the former California Department of Rehabilitation, for their data on the Centers for Independent Living outcomes.

Richard Gallo stated the Governor's transformation of behavioral health services was created without peer workforce community involvement. Peers were excluded. Peer workers have positive impacts on the behavioral health community, such as decreased hospitalization and justice involvement. Peer support is critical to helping individuals maintain recovery. The speaker stated the need to include individuals who have been dually diagnosed with intellectual disability and mental illness when discussing the SUD population. Families are struggling to get behavioral health services.

Jay Calcagno, Policy Analyst, California Council of Community Behavioral Health Agencies (CBHA), echoed Commissioner Rowlett's comments about raising up community engagement as part of transparency and accountability for the BHSA. The CBHA is proud to represent behavioral health providers across California. It is essential that providers and agencies continue to speak on the nuances and shifting paradigms within the behavioral health field, especially with the passage of Proposition 1, and identifying necessary metrics to protect California's most vulnerable communities. The CBHA also supports the need for continued transparency and accountability within the behavioral health continuum of care and appreciates the conversations heard today. The CBHA hopes to continue to be part of the conversation around bridging access to care through increased transparency and accountability.

Steve Leoni, consumer and advocate, agreed with the importance of client, family, and community voice. The speaker stated they agreed with the idea of "shut up and listen," but the problem with listening sessions is that the word "culture" is often associated with ethnic distinctions when it can also be a person's place in life. County and state personnel often live in a different cultural world from consumers and family members. This has to do with the concept of cultural humility, which is often forgotten. Individuals must look at their own biases when evaluating someone from a different culture and realize that they are seeing that person or hearing what that person says through their own lens. What is needed is not just a listening session, but a dialogue – a simple conversation to ensure the listener is really understanding.

Dr. Benhamida stated the data needs to include the new category Middle East and North Africa (MENA). The California Pan-Ethnic Health Network (CPEHN) did a webinar on the census and federal requirements. There may be state requirements coming up as well. The speaker suggested that the Commission have a presentation on MENA.

Dr. Benhamida stated, in terms of corrective action on behavioral health action plans, it is great that the Commission can do corrective action because in approximately five years, the Little Hoover Commission will possibly look at what has been accomplished. This has been a problem with the MHSA in the past.

Dr. Benhamida thanked Dr. Quist for his presentation and stated Dr. Quist has done a great deal in Sacramento County for community-based organizations. Dr. Quist stated the importance of disaggregated data. The speaker stated the hope that antiquated data formats will be updated.

Dr. Benhamida stated they have been emphasizing measures in scrutiny and the importance of standardization at the CARE Court Working Group meetings because there does not seem to be a standardization across counties for handling language interpretation and translation issues.

8: Lunch

The Commission took a short break and returned for a working lunch.

9: Proposition 1 Implementation: Exploring Commission Opportunities

Chair Madrigal-Weiss stated the Commission will hear an overview of Proposition 1 reforms that impact the Commission and its operations. She asked staff to present this agenda item.

Kendra Zoller, Legislative Deputy Director, stated Proposition 1 was approved by the voters in March of this year. It has a rolling implementation over the next several years. She provided an overview of the implementation dates for changes affecting the Commission and noted that most of the Commission's implementation changes are in January of 2025. Since the Commission historically does not meet in December, there are four Commission meetings left before some of the largest changes occur, including the change to 27 Commissioners. She reviewed each of the changes affecting the Commission and focused on those that occur January 1, 2025.

Commissioner Comments & Questions

Commissioner Danovitch asked how agendas will be managed with 27 Commissioners providing feedback on issues.

Executive Director Ewing agreed that it may be a challenge to gather Commissioner input with 27 members. He stated this conversation is about how to separate the decisions that Commissioners are most concerned about versus the decisions that take time that Commissioners are less concerned about. That will allow the movement of the less significant issues either to delegated authority to staff or the Chair or through the Committee structure.

Executive Director Ewing stated staff recognizes that, as new requirements are put in place for in-person participation, it will put constraints on the ability to achieve a quorum. After prioritizing the work and achieving a quorum, the Commission meeting structure then falls upon the Chair as facilitator to lead the discussion and cultivate a culture of process and respect among the Commissioners. He noted that some large Commissions run smoothly while others do not.

Commissioner Bontrager stated his understanding that, for the Commission to get its work done, it has heightened delegated authorization to determine what comes to this body.

Executive Director Ewing stated the law under the MHSA states that the Commission may meet four times per year or as it sees fit. Historically, the Commission has met ten times per year with sidebar conversations, such as site visits, on the Wednesday before Commission meetings. That was easier prior to the COVID-19 pandemic because

participating online was not considered. The culture, expectations, and workloads have now changed. The Commission has the authority to cite how often it meets but not how it meets, since the statute has been changed to require an in-person quorum.

Commissioner Carnevale asked if the law might change to update with current times because it is out of step with the rest of the world, or if it is locked in for legal reasons.

Executive Director Ewing stated it is locked in for legal reasons in response to historic issues about public presence for important decisions. These become the standards that drive policy decisions around open meeting laws. The law was not made for the Commission but for the 1,500 local government agencies that have the authority to give themselves raises and a history of not creating access, particularly for individuals for whom IT-driven strategies do not work. During the pandemic, public bodies saw a dramatic increase in participation. There are ongoing conversations about opportunities to continue to adjust the statutory requirements.

Commissioner Carnevale suggested holding four Commission meetings per year with an in-person quorum and the six other hybrid meetings per year with no decision making.

Chief Counsel Gallardo stated that is the system that the Bagley-Keene Open Meeting Act has allowed for committees. Committees can meet remotely although they still must have a physical presence.

Commissioner Carnevale stated the Committee system is effectively what a hybrid Commission meeting would be or an in-person Commission meeting where a quorum was not achieved. The Commission could meet for presentations and discussion but no action could be taken.

Chief Counsel Gallardo agreed.

Commissioner Danovitch stated it makes sense to review the Commission structure and governance prior to dramatically increasing the size of the Commission so that Commissioners will be ready to accept and integrate that increased size as effectively as possible. He suggested a review of different Commission structures to understand options and what should be striven for.

Commissioner Danovitch stated the importance of understanding the meaning in the changing of the Commission’s name from mental health to behavioral health and resulting implications. He stated, from his perspective, mental and behavioral are synonyms, but there may be other perspectives.

Executive Director Ewing stated staff will explore models and report back at the next meeting. The issue of whether mental health and behavioral health are synonyms was raised during a budget hearing by members of the Legislature. Staff will also explore that and report back. Clarity and consistency are required in the answer to that question.

Commissioner Chambers stated it would be great to explore what that means. When working on the psychiatric advance directives bill, there was an initial change that was struck out. Mental health was changed to behavioral health. Legal counsel from outside the state had analyzed that it had significantly changed the law relative to advance

directives. She stated she Is interested in how the meaning changes and where feedback is received on this issue to ensure there is a diverse pool of individuals who can weigh in from different communities on what that means.

Commissioner Rowlett stated that is a key point. Too many committees talk about inclusiveness but here is a place where it is easy to be more inclusive. It makes sense. He provided the example of the CARE Act and implications for communities. He stated the hope that the Commission will solicit the community around the Commission's name change and not underappreciate the implications associated with the moment.

Vice Chair Alvarez asked about changing up the structure. 27 Commissioners is a lot to manage for monthly all-Commissioner meetings; however, she asked about the opportunity to break up the work into work groups that would allow more opportunity for community engagement and not require 27 individuals to show up, which could be challenging.

Vice Chair Alvarez stated there are so many unknowns with this process; the Commission should lean in to more engagement, particularly during the start of this process, to answer questions and highlight challenges as it moves forward. Maybe those work groups will dissolve after a few years but at least there is an opportunity for more engagement with Commissioners and community at the beginning of the process. This lends itself to the transparency and open dialogue that this Commission is known for.

Commissioner Carnevale stated branding is a two-way street. It is important to understand what individuals think about the brand but the Commission can also be intentional about what it wants the brand to be. For example, emphasizing OAC as the name to signal that nothing has changed or emphasizing behavioral because the Commission learned that includes SUD will signal what the Commission is trying to accomplish. It does not replace what they think about it but brands can be shaped over time. He encouraged thinking about the intentionality of the messaging. It is a process.

Chair Madrigal-Weiss stated the Commission gets a lot of work done in its ten meetings per year. She suggested informational meetings every other month. She asked staff to research possible meeting models with larger numbers of members. She agreed with the importance of messaging and having a community engagement process for ideas on branding. She asked staff to come up with a few suggestions such as the California Behavioral Health Commission, or integrating SUDs and supports, and asking the Committees to come up with recommendations.

Commissioner Robinson stated it is important to consider behavioral expectations to make meetings manageable. He suggested time limits on comments, not to cut off conversation and dialogue but the logistics of managing that large of a group becomes difficult. He suggested a mandatory onboarding process with thoughtful behavioral expectations.

Commissioner Bontrager asked if the Commission has the authority to modify its name.

Executive Director Ewing stated it does not, but California has an 80-year-old entity called the Little Hoover Commission that is formally the Milton Marks Commission on California State Government Organization and Economy, and the First 5 Commission is

formally the California Children and Families First Commission. The idea is that the Commission can adopt a nickname that can be incorporated into the law or for common usage.

Chair Madrigal-Weiss asked for a volunteer to work with staff on these issues to help guide the process – Commissioner orientation and onboarding, number of meetings, pacing, the Commission's name, the role of Committees, and delegated authority.

- Commissioner Robinson volunteered to work with staff on Commissioner orientation.
- Commissioner Carnevale volunteered to work with staff on the Commission's name and branding.
- Chair Madrigal-Weiss volunteered to work with staff on the number and pacing of meetings and delegated authority.
- Commissioner Chambers volunteered to work with staff on the role of the Committees.

Chair Madrigal-Weiss recognized the need to elect a new Chair prior to the change in membership. She stated she will work with whomever is elected Chair later this year to support a smooth transition. Elections are planned at the October Commission meeting.

Chair Madrigal-Weiss stated Ms. Zoller has outlined these exciting opportunities ahead, but the Commission must function efficiently to leverage these changes. The Commission welcomes new voices from the behavioral health system, though maintaining an in-person quorum can be challenging due to diverse obligations. Delegated authority will help with some routine matters, but potential obstacles must be anticipated with 27 Commissioners. The volunteers will work with staff to propose options for organizing and facilitating the meetings for further discussion.

Commissioner Gordon stated, in his experience with the Commission, Commissioners have always done a great job of leaving their roles behind and making this a group effort to meet the larger goals rather than lobbying for their issues. He suggested being purposeful in helping to impart that culture to the new Commissioners. He suggested appointing a team to help onboard the new Commissioners.

Public Comment

Stacie Hiramoto expressed admiration to the Commission for the big changes ahead. She suggested that Commissioners and staff attend a 40-member California Behavioral Health Planning Council meeting to see what works for them. The speaker noted that they also have structured Committees. The speaker suggested consulting with the public along with the Commission volunteers, Commission Committees, and staff on recommendations for Commissioner orientation and onboarding, number of meetings, pacing, the Commission's name, the role of Committees, and delegated authority.

Stacie Hiramoto stated the hope that updating the rules and procedures will be a transparent process with community engagement, and spoke in support of maintaining the current Commission Committees. The speaker suggested including the definition of

a Committee versus a Subcommittee. The speaker asked that the Commission specify how these decisions will be made and with what criteria.

Steve Leoni stated they are a member of the Planning Council, which meets for three days to three and a half days four times a year with other meetings as needed. Permanent Planning Council Committees are made up of members of the Planning Council. The speaker stated most of the Planning Council work is done in Committees. The Committees make most of the decisions and the full Planning Council does not need to verify those decisions. The speaker suggested the Planning Council as a resource.

Jay Calcagno provided an overview of the background of the CBHA and asked, as the Commission considers changes to its governance, that community-based organizations and communities be included in every step. The CBHA fears that services that were once supported by Proposition 1 in the past will no longer be supported. The CBHA is willing to work with the Commission and others to ensure that there is continuity of care for communities served.

10: Early Psychosis Strategic Plan Draft

Chair Madrigal-Weiss stated the Commission will hear an update on the efforts to draft a strategic plan for early psychosis intervention. She asked staff to present this agenda item.

Executive Director Ewing introduced Kana Enomoto, Director of Brain Health, McKinsey and Company. Ms. Enomoto and her team with support and guidance from community, state, national, and international experts have been supporting the Commission's work in response to the direction from the Commission that dates back several years but, more recently, direction to use a portion of the early psychosis funding received in the past to develop an Early Psychosis Intervention (EPI) Strategic Plan to scale these services.

Executive Director Ewing stated the 80-page Early Psychosis Care in California strategic plan draft and other handout materials were distributed to Commissioners. He provided an overview, with a slide presentation, of the background of projects funded by the Commission on early psychosis, coordinated specialty care, and partnerships with UC Davis and counties.

Executive Director Ewing stated the Commission has contracted with McKinsey and Company to document the extent that Californians who develop psychoses have access to early psychosis care consistent with best practices, estimate the cost of expanding access to cover 90 percent of the need based on best available research, and develop a strategic plan that identifies the core elements necessary to achieve that 90 percent coverage and the steps to be successful.

Executive Director Ewing stated the Commission engaged peers and family members, commercial insurers, legislative staff, partners and other state agencies, and experts from around the country and internationally as part of the community consultation process. It is important that the technical piece, which is essential for implementing the strategic plan, was correct and that the foundation was focused. It will take a few

months to share this strategic plan broadly. Staff will do public engagement and work with Committees, advocacy groups, and youth interns.

Executive Director Ewing provided an overview of early psychosis and the impact on individuals and systems. Psychosis is a reflection of the most challenging behavioral health conditions that an individual and their family can face in a community. Early psychosis intervention represents the best opportunity to engage and support recovery. Untreated psychosis can impact health care, employment, housing, criminal justice, and caregiving. Research suggests that responding effectively does a good job of reducing the negative impacts of psychosis, including improving housing outcomes and a dramatic reduction in criminal justice involvement.

Executive Director Ewing stated a Coordinate Specialty Care (CSC) model provides a holistic intervention model for treating early psychosis. Engaging early and effectively and surrounding individuals with supports that include traditional medication and therapy but also peer and family support, supported employment, and community outreach dramatically improves outcomes in comparison to what is often called typical care. Research shows that CSCs are highly effective with reductions in inpatient days, improved employment, and education outcomes. Research has begun to define the standard of care. There are tensions in the field between who should be served under this model based on the research versus whether the model applies outside the bounds of the research. There are also tensions over whether engagement should begin upon a first episode of psychosis or through an upstream strategy typically referred to as clinical high risk. These are normal and natural tensions in this space.

Ms. Enomoto continued the slide presentation and discussed the impact of scaling early psychosis intervention. She provided a high-level summary of preliminary findings of the initial EPI model. She stated McKinsey found, with an investment over the course of ten years, an organization would actually be where it was strategically trained to reach 90 percent of the affected population or 135,000 more individuals, while saving the state, families, employers, and individuals $12 billion. It is possible to reach, treat, and help nine times as many people, nine times as many families, while saving approximately $1 billion per year.

Ms. Enomoto stated McKinsey defined it as people getting coordinated specialty care within the first year or two of their initial onset of psychosis. The greatest cost savings are when individuals enroll early on. There is research that people who come in later can still benefit but they tend to generate higher health care costs. The preventive nature of early intervention is important. The expectation is that individuals do not transfer from CSC to nothing but from CSC to something that is also robust and evidence-based.

Commissioner Comments & Questions

Commissioner Robinson stated there will be people who will say that this is cost avoidance and is not true savings. He asked how this can be messaged in a way that heads off the sceptics.

Executive Director Ewing provided two real-world examples:

- The state of California increased funding for the Department of State Hospitals approximately two years ago by $1.2 billion. This is not the avoidance of future potential costs; this is cost avoidance that results in savings, heavily dependent on how it is implemented.
- The Commission invested a small amount of funding to support a research project with Kaiser Health System. Kaiser tracked 60 clients getting CSC in comparison to 60 clients getting typical care who were receiving services under Kaiser through a partnership with the Aldea Children and Family Services. Within six months, Kaiser saw a dramatic reduction in direct costs associated with emergency room utilization.

Executive Director Ewing stated, in addition to doing this economic analysis and projections, staff has been working with key leaders in positions where the demand for this is explicit and clear.

Commissioner Carnevale asked the reason for taking an overly conservative estimate and stopping at ten years. He presumed there are reasonable cost estimates over the lifetime for the care of someone who is psychotic and not treated.

Ms. Enomoto stated they are trying to be robustly evidence-based. She appreciated the sentiment of thinking longer, but there have not been those kinds of longitudinal CSC studies that have followed individuals over the course of 20 years. She stated McKinsey was also conservative in terms of not adding in the value of a statistical life, but it is known that, within the first year of experiencing psychosis, suicide risk is markedly increased. She stated the Commission could be more daring, but on the other hand the data shows that nine times more individuals are being served whose lives will be transformed by this type of intervention. She stated she sometimes takes offense that the return on investment must be demonstrated on delivering the standard of care to people who are in great need.

Commissioner Carnevale stated he understands that maybe there is not a longevity study, but the system costs that support these individuals are known. He suggested making an estimate around that, even if it is more speculative.

Executive Director Ewing stated the models and risk calculations in areas of health care have not been applied to the behavioral health space. The ten-year timeline is based on standards coming out of the Congressional Budget Office as standard practice. Because this is a government strategy, this study adhered to the governmental culture. Stories about the 13-year-old who brings a knife to school when they are behaving rationally and normally and taking good care of themselves in their minds because they hear voices in their head and other stories alone should be enough.

Commissioner Carnevale stated that makes sense, but on the other hand, in order to elevate this disparity between behavioral health and the rest of the health care system, he suggested saying “if this were calculated the way cancer is calculated, then it would look like X,” which would accomplish both objectives at once.

Commissioner Gordon stated the other message in the example given is that the surveillance of young people has been vastly expanded to detect these potential problems before they occur. This is free. In the case of the 13-year-old, the teachers

may have had training, which sometimes is a problem because of the viewpoint that teachers have enough to do. Sacramento uses a model that puts a mental health clinician in the schools so there is a trusted source to validate that direction and diagnosis. He stated the need to ensure that there is broader surveillance of children and youth in as many ways as can be created. This includes 3- and 4-year-olds in child care centers.

Commissioner Carnevale stated the piece that is missing is where innovation intersects this. Data from UC Berkeley and UCSF proves that it is not just about the ability to catch cancer at stage 1 but to catch it before it forms. He stated the need to test 3- to 5-year-olds who may be at risk long before the numbers being used in the McKinsey study. He suggested adding a section on innovation that captures additional programs that should be invested in.

Chair Madrigal-Weiss stated the teachers recognized that there was a problem with the 13-year-old at school. Five years ago, that child would have been sent to the principal, it would have been a disciplinary act of suspension or expulsion, and no one would have guessed what prompted the student's behavior. The fact that there are now teachers who pause and ask questions is to be applauded.

Commissioner Bontrager stated, unlike what Commissioner Carnevale was saying, where there is a market failure, government steps in. Government has paid more of its share of the costs of these interventions in the private sector, whereas commercial plans will pay for cancer treatment. CSC is not an essential health benefit but it should be; otherwise, individuals fail and end up in the Medi-Cal system where the public bears that burden more than the commercial plan. He stated the need to consider whether the costs are shared fairly and whether more obligations can be imposed on the commercial world to cover this. There is precedent for this – for example, the new multi-payer fee schedule at schools that compel commercial plans to cover certain mental health services provided at school. The Commission needs to not only look at cost avoidance but who bears those costs. The commercial or private sectors should not be exempt from bearing the cost of these services.

Executive Director Ewing reviewed the three-pronged strategy on commercial insurance:

- The essential health benefit, parity, regulatory argument – staff is talking with the Governor and the Legislature about that strategy consistent with positions the Commission has taken in the past.
- The Kaiser work was to see if there was an internal economic incentive for them to volunteer CSC. Staff is now talking with them about whether their own research was robust enough to change the actuarial models that drive their decisions around making this the default practice.
- Engaging with CalPERS to say to the insurance marketplace, "if you are going to play in the marketplace with us, you will have a CSC benefit."

Executive Director Ewing stated these conversations are underway.

Commissioner Bontrager stated he supports any lever staff wants to push because the Commission needs to push all of them.

Presentation, continued

Executive Director Ewing continued the slide presentation and discussed the path forward to get from 10 percent to 90 percent, including the vision, implementation support workstreams, activities, and next steps for the Draft EPI Strategic Plan. He stated the seven foundational elements of the strategic plan in addition to vision, equity, and ecosystem engagement are the key goals of broad and compelling public awareness, access, and quality, and the foundation levers of sustainable funding, workforce and capabilities, data and accountability system, and the infrastructure for success.

Executive Director Ewing stated moving this forward will be challenging in terms of all the pieces that are important to connect with the DHCS, CalHHS, and managed care. Four Implementation Workgroups will be convened to define goals, design strategies, and align on roles and responsibility. They will work on integrated coordination, performance management, change management, and a communications plan.

Executive Director Ewing asked for feedback on whether the EPI Strategic Plan is something the Commission should do or something that Administratoin should do, and how the Commission can partner with them.

Commissioner Discussion

Commissioner Carnevale asked about the number of counties that may be interested in engaging in a pilot program.

Executive Director Ewing stated staff is working with nine counties to develop CSC systems in early investments to result in a launch of new programs; the development of a Center of Excellence at UC Davis to provide technical assistance; a system for consistent data to gather, analyze, and return the data to partners; and the infrastructure for collaborative learning across the nine counties, including a hub-and-spoke model supported by UC Davis.

Executive Director Ewing stated the bottom line is that this approach of $20 million in grants every two years will not work in large part because the financing does not match the model in terms of what Medi-Cal will pay for. Medi-Cal will pay for approximately 80 percent of the components of CSC. Commercial insurance falls further behind that. Even Medi-Cal requires the counties to use their MHSA funds to draw down the federal money. It is not clear that the programs today can be sustained under the workforce model or that the Commission is persisting as assertively as it needs to in terms of both fidelity to what is known today and the capacity to learn today to shape the work of tomorrow because of the way fiscal, accountability, and other incentives are structured.

Commissioner Carnevale stated this is where the capital innovation can come in with public/private insurance. One way to look at this is a rolling waterfall, but the other way is to say, if this is fixed in one day, it would be a one-time investment to go from 10 percent to 90 percent. That is a specific cost and, from a modeling standpoint, if the system is infused with that money, there is a specific number to change that dynamic,

there will be a return of some kind that would be attractive, and that is where a public/private partnership can be interesting.

Executive Director Ewing stated his presumption is, if the financing system can be fixed, then that can be done. But, in the absence of an alignment between a reliable revenue stream, the system is transacting on the goodwill of counties to tap into limited discretionary dollars. That is the way this system has been designed and that is why the system is the way it is today.

Ms. Enomoto reminded everyone that at least 50 percent of young people have commercial insurance. Reaching beyond the state systems, at least 200 more CSC programs will be required around the state. This will require derisking and many partnerships.

Commissioner Carnevale stated his understanding that, when young people reach that point where they want serious services, they move to the public sector. He asked whether that population would move to be uninsured anyway, if it were actually being penetrated.

Ms. Enomoto stated the goal is to keep young people in school and working. This becomes a condition like any other childhood health condition that can be well managed without having to leave their current status. Currently, that is something that young people would do because they cannot access CSC programs when they have commercial insurance.

Executive Director Ewing stated this draft strategic plan is in the beginning stages of gathering feedback. Commissioners bring a level of expertise that needs to be infused into this work. He asked Commissioners to share their concerns and thoughts with staff to help move this plan from a conception paper into an operational strategy that will shape policy and practice moving forward. There is a bill moving through the Legislature asking the Commission to deliver this plan. Staff is currently talking with the Governor's Office. The time is right. The goal is to come back with the final EPI Strategic Plan at the November Commission meeting.

Public Comment

Kit Wall, Words to Deeds, asked if McKinsey factored in economic modeling or speed to accurate diagnosis.

Jay Calcagno stated the CBHA appreciates its inclusion in the process for feedback with the draft strategic plan and looks forward to hearing feedback from Commissioners and communities. The CBHA values early intervention approaches like this. The speaker asked the Commission to consider the thin but important lines between primary, secondary, and tertiary prevention and the various culturally-specific modalities that can be uplifted to support diverse communities. This is an opportunity to highlight the most impactful interventions across the state that can serve the diverse needs of many different populations.

Chair Madrigal-Weiss stated there will be many opportunities for additional feedback on the draft EPI Strategic Plan.

11: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on August 22nd in San Diego. There being no further business, the meeting was adjourned at 3:09 p.m.

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
July 25, 2024

Motion #: 1

Date: July 25, 2024

Proposed Motion:

That the Commission approves the May 23, 2024 Meeting Minutes.

Commissioner making motion: Commissioner Robinson

Commissioner seconding motion: Commissioner Brown

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

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☒	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☒	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Danovitch	☒	☐	☐	☐	☐
10. Gordon	☒	☐	☐	☐	☐
11. Mitchell	☐	☐	☐	☒	☐
12. Robinson	☒	☐	☐	☐	☐
13. Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	9	0	1	4	1

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
July 25, 2024

Motion #: 2

Date: July 25, 2024

Proposed Motion:

That the Commission approve the Consent Calendar that includes:

(1) First, funding for Sierra County to join the Semi-Statewide Enterprise Health Record Multi-County Collaborative Innovation Project for up to $910,906; and
(2) Second, that the Commission adopt the Resolution authorizing worker's compensation insurance coverage for persons providing voluntary services to the Commission without compensation within the meaning of Labor Code 3363.5 and California Government Code 3111.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☒	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Danovitch	☒	☐	☐	☐	☐
10. Gordon	☒	☐	☐	☐	☐
11. Mitchell	☐	☐	☐	☒	☐
12. Robinson	☒	☐	☐	☐	☐
13. Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☐	☐	☐	☒	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	9	0	0	5	1

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
July 25, 2024

Motion #: 3

Date: July 25, 2024

Proposed Motion:

That the Commission approves the Fiscal Year 2024-25 expenditure plan, and associated contracts.

Commissioner making motion: Vice Chair Alvarez

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☒	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☐	☐	☐	☒	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Danovitch	☒	☐	☐	☐	☐
10. Gordon	☒	☐	☐	☐	☐
11. Mitchell	☐	☐	☐	☒	☐
12. Robinson	☒	☐	☐	☐	☐
13. Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**9**	**0**	**0**	**5**	**1**

AGENDA ITEM 5

Action

August 22, 2024 Commission Meeting

Consent Calendar

Summary

The Commission will consider approval of the Consent Calendar which contains the following item:

1) Innovation funding request from Orange County to join Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative
2) Innovation **extension** funding request from Orange County for their previously approved Community Program Planning Project.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held for future consideration at the discretion of the Chair.

1) Orange County: Psychiatric Advance Directives: Phase 2, Multi-County Collaborative

Orange County is requesting $4,980,470 in Innovation funding to participate in Phase Two of the Psychiatric Advance Directives (PADs) multi-county collaborative, joining both Fresno and Shasta Counties who were approved on May 25, 2024, for $5,915,000 and $1,000,000, respectively.

The first cohort of the PADs project consisted of seven counties and was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training and a toolkit, as well as create a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and “live” use of PADs. At this time, Fresno and Shasta County are ready to pilot Phase Two; however, up to fifteen counties may join Phase Two by the end of the year.

Phase Two goals include engagement for new counties, collaboration amongst stakeholders, training and accessibility, testing in a live environment, evaluation, and transparency through www.padsCA.org.

Behavioral Health Services Act Alignment and Sustainability

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care including veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the Commission's Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery.

On April 23, 2024, The Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see page 4-5).*

Regarding sustainability, PADs has received support from current legislative action (AB2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the hope that it will secure ongoing funding from various agencies.

The Community Program Planning Process

In Phase Two, Orange County is continuing to prioritize their focus on individuals who access crisis support services.

The County indicates data regarding the use of crisis services between January 1, 2024 through June 30, 2024:

- 22,084 calls received through County's Behavioral Health Line
    - 6,267 of these calls were a possible crisis
        - 1,249 were resolved via phone support
        - 5,018 required mobile crisis dispatch

Many of the mobile crisis calls that were dispatched (77%) were to assess adults over 18 years of age, resulting in 40% requiring hospitalization or involuntary holds. The County indicates

the ability for behavioral health providers and law enforcement to have access to an individual's PAD would greatly increase the ability to provide quality care and treatment.

Throughout Phase 1 of the collaborative, the County states their community has made tremendous progress in terms of awareness and engagement surrounding PADs and is eager to test the platform in Phase 2.

The County's 30-day public comment period began on March 11, 2024, followed by a public health board hearing on April 17, 2024. The County received Board of Supervisor approval on June 4, 2024.

After the public comment period, the County held 12 community engagement meetings to discuss updates to the MHSA plans as well as this project, responding to specific questions surrounding PADs project partners, budget, PADs legislation, and target populations for the use of PADs.

This project for Orange County to join the PADs Collaborative was initially shared with the Commission's community partners and listserv on July 18, 2024 and the final sharing of this project was again shared on July 26, 2024.

In response to the Commission's request for feedback, two separate emails were received dated July 18, 2024 and July 30, 2024. Commission staff forwarded both comments to Orange County and the Contractor and were provided responses or were contacted directly to address concerns.

The received comments and responses to the comments have been included as enclosures in Commissioner's packets.

2) Orange County: Community Program Planning Extension Request

Orange County was originally approved for up to $950,000 of innovation funding over five years to support the Innovation-related Community Program Planning Process (INN related CPPP).

Due to the County's procurement process, the project start date was delayed by 18 months which is when Senate Bill 326 and Proposition 1 discussions became known publicly. The County decided to delay the start of this project until knowing how the Mental Health Services Act (MHSA) would be impacted. **This project has not started yet due to these delays.**

Orange County is now requesting Commission approval for an additional amount up to $1,000,000 in innovation funding to build on the approved plan to take the community planning process to the next phase, which will ultimately result in the County's behavioral health system re-design due to the passing of Proposition 1.

The additional funding will allow the County to expand upon the original project goals by including activities that will support the transition to the Behavioral Health Services Act and would like input and feedback from their community on how best to create a new path forward.

Additional funding of $1,000,000 for this extension request will support a comprehensive strategy and structure for a robust community program planning and stakeholder engagement, efforts to increase attendance at stakeholder meetings and gain participation of diverse communities, discussion of financial planning with the public sector, key informant interviews, listening sessions, and focus groups with County staff and stakeholders, capacity assessments and system-level needs of individuals who qualify for services, workforce needs assessment, and assessment of homeless services and supports.

Behavioral Health Services Act Alignment and Sustainability

This project will allow the County to focus on all individuals who access the County's behavioral health system: individuals who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care.

These additional activities will allow the County to prepare for changes in the CPP process under BHSA and identify strategies for meaningful community engagement. The successful strategies and lessons learned from implementation will be continued in future CPP activities and sustained through community planning funds under BHSA.

The Community Program Planning Process

The County's 30-day public comment period began on March 11, 2024, followed by a public health board hearing on April 24, 2024. The County received Board of Supervisor approval on June 4, 2024.

After the public comment period, the County held 12 community engagement meetings to discuss updates to the MHSA plans as well as this project.

Orange County proposes to spend $1,000,000 of additional Innovation funding with this extension request for a total project amount of $1,950,000 over five years.

This extension request was initially shared with the Commission's community partners and listserv on July 18, 2024 and the final sharing of this project was again shared on July 26, 2024.

No comments were received in response to the sharing of this extension request.

Presenters: None

Enclosures (4): (1) Commission Community Engagement Process; (2) Orange County Analysis: Community Program Planning Innovation Project Extension; (3) Orange County Analysis: Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project; (4) Comments and responses received regarding PADs Phase 2 Project

Handouts: None

Additional Materials (2):
Links to the final Innovation projects are available on the Commission website at the following URLs:

Psychiatric Advanced Directives (PADs):
https://mhsoac.ca.gov/wp-content/uploads/Multi-County_INN-Project_PADs_Phase2_Orange-County.pdf

Community Program Planning Extension Request:
https://mhsoac.ca.gov/wp-content/uploads/Orange_INN-Project_CPP-EXTENSION.pdf

Proposed Motion:
That the Commission approve the Consent Calendar that includes:

(1) Funding for Orange County to join Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $4,980,470; and
(2) Funding for Orange County's Extension of the Community Program Planning Innovation Project for an additional amount of up to $1,000,000, for a total project amount of $1,950,000.

Mental Health Services
Oversight & Accountability Commission

Commission Process for Community Engagement on Innovation Plans

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

Sharing of Innovation Projects with Community Partners

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

Innovation (INN) Project Name:	**Community Program Planning Innovation Project – EXTENSION**

Original Approval History:

Original Approval Date:	May 25, 2022
Original Amount Approved:	$950,000
Duration of INN Project:	Five (5) Years
Project Start Date:	Not Started (See Background below)

Current Request:

Additional INN Funding Requested:	$1,000,000
Additional Time Requested:	N/A
MHSOAC consideration of INN Project:	August 22, 2024

Review History:

Approved by the County Board of Supervisors:	June 4, 2024
Mental Health Board Hearing:	April 24, 2024
Public Comment Period:	March 11, 2024 through April 15, 2024
County submitted INN Project:	July 11, 2024
Date Project Shared with Stakeholders:	July 18, 2024 and July 26, 2024

Background:

Orange County was originally approved for up to $950,000 of innovation funding over five years to support the Innovation-related Community Program Planning Process (INN related CPPP).

Due to the County's procurement process, the **project start date** was delayed by 18 months which is when Senate Bill 326 and Proposition 1 discussions became known publicly. The County decided to delay the start of this project until knowing how the Mental Health Services Act (MHSA) would be impacted.

Original Project Approval:

Approved on May 25, 2022, the County proposed to utilize innovation approved funds towards the following activities to meaningfully engage their partners in proposal development and feedback throughout the duration of the project:

- **Innovation staff time** to research concepts, develop materials, and coordinate meetings
- **Translation and Interpretation services** to support County's diverse community
- **Consultants and Subject Matter Experts** to assist in facilitating meetings
- **Marketing Strategies** to reach the broader community
- **Program supplies** (stipends, transportation costs for partners to attend meetings, cost of printing and discussion materials, etc.)

The Mental Health Services Act (MHSA) specifies that each county may spend up to 5 percent of their respective, total MHSA allocations on the CPPP process. The Act and regulations further *require* every County to ensure that the CPPP process is adequately staffed, that a diverse set of stakeholders participate in the process - including persons with lived experience, and that appropriate training is provided to participants to enable more meaningful participation. Additionally, authority to spend INN funds on INN-related CPPP has precedence. The California Department of Mental Health's Information Notice 08-36 previously advised counties as to the maximum amount (25%) of INN funds they could ask for and apply to INN-related CPPP during the initial (Fiscal Year 2008-09 and Fiscal Year 2009-10) roll-out of the Innovation Component. The Department of Health Care Services is not opposed to counties using INN funds for the CPPP if the Commission approves budget authority for that purpose.

Within the original project request, Orange County stated in their proposal that they expect an increase in MHSA revenue annually (from $8 million to $11 million) and proposed to utilize that increase towards dedicated innovation staff time and resources to develop new Innovation projects, engage meaningfully with their partners and demonstrate their commitment to engage their community in the development and implementation of Innovation projects. At the time this project was approved, their current expenditures were an estimated $7.3M, leaving $73.7M in available INN funding through FY 2027-28. Orange County originally planned to use approximately 1.3% of their INN funding to determine the use of $73.7 M, which is a reasonable request.

Previous community efforts surrounding the MHSA innovation component revealed that community planning requires more time and effort in comparison with other MHSA components. Additionally, the community planning process that contributes to the idea and continued development of an innovation project requires community-wide efforts and must be inclusive and representative of the community it serves. Orange County realized the continued need for meaningful community partner engagement and the necessity to reach diverse communities who remain unserved and underserved.

Extension Request

Orange County is now requesting Commission approval for an additional amount up to $1,000,000 in innovation funding to build on the approved plan to take the community

planning process to the next phase, which will ultimately result in the County's behavioral health system re-design due to the passing of Proposition 1.

At the time this project was originally brought forward and approved, the County did not realize there would be a mandated transformation to California's public behavioral health system. This change brings about different funding components within MHSA, may result in the removal of some County-run programs and expands the community involvement needed to develop Three Year Integrated Plans and future forecasting of county programs and services.

The additional funding will allow the County to expand upon the original project goals by including activities that will support the transition to the Behavioral Health Services Act and would like input and feedback from their community on how best to create a new path forward.

Additional funding of $1,000,000 for this extension request will allow Orange County to incorporate the following activities in addition to the original goals previously established (see pages 2-3 for details of all listed additional proposed activities):

- Development and implementation of a comprehensive strategy and structure for a robust community program planning and stakeholder engagement process
- Identify all relevant stakeholders within behavioral health system in order to increase attendance at stakeholder meetings and gain participation of diverse communities
- Financial planning discussions with the public sector for economic analysis of various available funding streams, financial performance measures, and cost allocation and rate setting
- Key informant interviews, listening sessions, and focus groups with County staff and stakeholders
- Conduct capacity assessments and system-level needs of individuals who qualify for MHSA/BHSA services
- Workforce needs assessment focusing on linguistic capability, provider diversity, and education and training needs
- Assessment of homeless services and supports

Behavioral Health Services Act Alignment and Sustainability:

This project will allow the County to focus on all individuals who access the County's behavioral health system: individuals who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care.

These additional activities will allow the County to prepare for changes in the CPP process under BHSA and identify strategies for meaningful community engagement. The successful

strategies and lessons learned from implementation will be continued in future CPP activities and sustained through community planning funds under BHSA.

Community Planning Process

Local Level

The County's 30-day public comment period began on March 11, 2024, followed by a public health board hearing on April 24, 2024. The County received Board of Supervisor approval on June 4, 2024.

After the public comment period, the County held 12 community engagement meetings to discuss updates to the MHSA plans as well as this project.

Orange County proposes to spend $1,000,000 of additional Innovation funding with this extension request for a total project amount of $1,950,000 over five years.

Commission Level

This extension request was initially shared with the Commission's community partners and listserv on July 18, 2024 and the final sharing of this project was again shared on July 26, 2024.

No comments were received in response to the sharing of this extension request.

The Budget

The County is requesting an additional authorization to spend up to $1,000,000 in MHSA Innovation funding for this project over a period of five years, for a total project amount of $1,950,000. This additional funding will allow the County to support the restructuring of its community planning process in response to Proposition 1 and the Behavioral Health Services Act.

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations. Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability (see page 3).

STAFF ANALYSIS – ORANGE COUNTY

Psychiatric Advance Directive Multi-County Collaborative

Innovation (INN) Project Name: **Psychiatric Advance Directives (PADs) – Phase 2**

MHSOAC consideration of INN Project: **August 22, 2024**

Review History

New County Joining PADs Phase 2:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	BOS Approval
Orange	$4,980,470	4 Years	3/11/2024-4/15/2024	4/24/2024	6/4/2024
TOTAL:	**$4,980,470**				

Previously Approved Counties - May 25, 2024:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	BOS Approval
Fresno	$5,915,000	4 Years	2/16/2024-3/16/2024	3/20/2024	5/7/2024
Shasta	$1,000,000	4 Years	4/19/2024-5/19/2024	5/22/2024	Pending
TOTAL:	**$ 6,915,000**				

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase access to mental health services to underserved groups, promote interagency and community collaboration related to Mental Health Services, supports or outcomes, and increases the quality of mental health services, including measured outcomes.*

This Proposed Project meets INN criteria by *introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.*

Project Introduction:

Orange County is seeking approval to use innovation funds to join Fresno and Shasta Counties in Phase Two of the Psychiatric Advance Directive (PADs) Multi-County Collaborative. This project will perform live testing and evaluation of the use of a digital Psychiatric Advance Directive utilizing the web-based platform. The overall goals of Phase Two will focus on engagement, collaboration, training, testing, evaluation, and transparency.

Psychiatric Advance Directives (PADs) are used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental health condition. They generally are used to support individuals at risk of a mental health crisis where decision-making capacity can be impaired. PADs allow an individual's wishes and priorities to inform mental health treatment. Like their general health care counterpart, a PAD can also allow an individual to designate proxy decision-makers to act on their behalf in the event the individual loses capacity to make informed decisions.

PADs Phase One Background:

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training, a toolkit, as well as the creation of a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Phase One will culminate with the following goals being achieved:

- Standardized PAD template language for incorporation into an online and interactive cloud-based webpage, created in partnership with Peers and first responders
- Creation of a PADs facilitator training curriculum that will utilize a training-the trainer model for facilitation
- Creation of easily reproducible technology that can be used across California while maintaining sustainability
- Legislative and policy advocacy to create a legal structure to recognize PADs
- Evaluation of the development and adoption of PADs, the understanding of PADs, and the user-friendliness of PADs with measured outcomes

The goals for Phase Two are to take achievements from Phase One and test them in a live environment following training on the use and completion of PADs occurs.

Behavioral Health Services Act Alignment and Sustainability:

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care, including but not limited to: Veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the current Commission Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery (see Appendix for Orange County, pages 42-43, for detailed information).

On April 23, 2024, the Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see pages 5-6).*

Regarding sustainability, PADs has received support from current legislative action (AB 2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the overarching goal of securing ongoing funding from various agencies. Orange County is also encouraging their Peer Workforce to seek Peer Certification, allowing reimbursement through Medi-Cal billing.

What is the Problem:

As outlined in Phase One of the PADs project, there is widespread support for the use of PADs to empower people to participate in their care, even during times of limited decision-making capacity. PADs can improve the quality of the caregiver-client relationship and improve health care outcomes. The Joint Commission on the Accreditation of Healthcare Organizations recognizes the value of psychiatric advance directives for treatment decisions when an individual is unable to make decisions for themselves (JCAHO, Revised Standard CTS.01.04.01).

While psychiatric advance directives were first put utilized in the United States in the 1990s, and have widespread support, research suggests their use is limited by lack of awareness, and challenges with implementation.

Although 27 states have passed laws recognizing PADs, most PADs are incorporated with the main emphasis on physical health. Adding to this is that there is not a standardized template for individuals, or their support systems, to access it when they might need it the most.

With the increasing rates of mental illness and high rates of recidivism, steps need to be taken so that directives are in in place in the event a person experiences a psychiatric episode.

Phase One explored the utility of PADs as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement. Phase Two will focus on the effectiveness of a PAD with training and live testing.

Innovation project overview:

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and "live" use of PADs. At this time, Orange County is joining Fresno and Shasta Counties; however, up to fifteen counties may join Phase Two by the end of this calendar year.

Phase Two goals include the following (see pages 5-6 for details):

1. Engagement for new counties joining the project. Counties will work with first responders, behavioral health departments, courts, local NAMI chapter and peer organizations to better understand PADs and how to successfully utilize a PAD.
2. Collaboration amongst stakeholders will continue surrounding legislative efforts and to inform and enhance the use and access of a standalone PAD when tested in a "live" environment. Some of the groups that will partner include but are not limited to county staff, peer support specialists, Painted Brain, Cal Voices, Disability Rights of California, local NAMI chapters, California Professional Firefighters, California Sheriff's Association, California Hospital Association, Department of Justice, Patient Right's attorneys to name a few.
3. Training will be the main component within this project and the use and accessibility of a PAD will be closely monitored throughout the project. Training modules will be provided for first responders, crisis intervention teams, CARE Courts for judicial staff, Peer training for Peer Support Specialists and peer supports within the court system, and counties who have identified their own priority population.
4. Testing will occur after training has been provided. The testing phase will occur in a live environment to determine the ease of use, number of PADs that have been completed, and the disposition of law enforcement and hospitals to assess if there was a reduction in the number of 5150s requiring hospitalization due to the availability and use of a PAD.
5. Evaluation of Phase Two will continue from Phase One; however, emphasis will be on the intersectionality of the use of a PAD combined with the technology platform.

Evaluation will include data obtained through interviews and observation and will meet all Institutional Review Board (IRB) requirements.

6. Transparency will be made available as Phase Two progresses on the project's website: www.padsCA.org.

The purpose of Phase Two will be to perform in-depth training, testing and evaluation of the tasks completed during Phase One.

Discussion of County Specific Regulatory Requirements

Orange County (see Appendix, page 40)

In Phase Two, Orange County is continuing to prioritize their focus on individuals who access crisis support services.

The County indicates data regarding the use of crisis services between January 1, 2024 through June 30, 2024:

- 22,084 calls received through County's Behavioral Health Line
    - 6,267 of these calls were a possible crisis
        - 1,249 were resolved via phone support
        - 5,018 required mobile crisis dispatch

Many of the mobile crisis calls that were dispatched (77%) were to assess adults over 18 years of age, resulting in 40% requiring hospitalization or involuntary holds. The County indicates the ability for behavioral health providers and law enforcement to have access to an individual's PAD would greatly increase the ability to provide quality care and treatment.

Throughout Phase 1 of the collaborative, the County states their community has made tremendous progress in terms of awareness and engagement surrounding PADs and is eager to test the platform in Phase 2.

The County's 30-day public comment period began on March 11, 2024, followed by a public health board hearing on April 24, 2024. The County received Board of Supervisor approval on June 4, 2024.

After the public comment period, the County held 12 community engagement meetings to discuss updates to the MHSA plans as well as this project, responding to specific questions surrounding PADs project partners, budget, PADs legislation, and target populations for the use of PADs (see pages 45-46, and 48-54 for more information).

Orange County proposes to spend $4,980,470 in Innovation funding towards this multi-county collaborative.

Commission Level

This project for Orange County to join the PADs Collaborative was initially shared with the Commission's community partners and listserv on July 18, 2024 and the final sharing of this project was again shared on July 26, 2024.

In response to the Commission's request for feedback, two separate emails were received dated July 18, 2024 and July 30, 2024. Commission staff forwarded both comments to Orange County and the Contractor. The County and Contractor responded to the individuals with additional information on the project.

The received comments have been included in Commissioner's packets as an enclosure.

Learning Objectives and Evaluation (see pages 22-26):

Burton Blatt Institute will continue their work on this project and be the primary subcontractor, working in collaboration with other subcontractors, to perform the evaluation based on the established learning questions during this testing and implementation phase.

The following **individual and service-level** questions have been identified as follows:

(1) In the opinion of PADs county managers, did Phase 2 counties achieve the outcomes they specified in their work plans to test and implement the PADs web-based platform with their priority peer populations and community-based stakeholders?

(2) In the opinion of mental health legislative advocates, did PADs and its web-based platform address the county's goals for mental health treatment and recovery and for reducing the frequency of involuntary hospitalizations?

(3) In the opinion of peers, did accessing and using the PADs web-based platform positively affect their lives over the three-year evaluation period?

a. Did they experience increased feelings of empowerment, self-direction, and hope for the future by creating a web-based PAD?

b. Did they have better experiences with law enforcement, first responders, hospitals, and others when their web-based PAD was accessed and used when they were in crisis?

c. Did using a web-based PAD decrease the length of time when they were in crises and could not make their own decisions?

d. Did the use of a web-based PAD decrease the frequency of involuntary psychiatric commitments?

e. Did they feel that having a web-based PAD improved the quality of crisis response services they receive from their mental health, homelessness, criminal justice, and other agencies who work with them?

f. Was their crisis support system, including peers, family members, and stakeholder agency staff, strengthened by their use of a web-based PAD?

(4) In the opinion of community agency stakeholders, how did access and use of the PADs web-based platform positively affect how law enforcement, first responders, hospitals, and others serve peers when they are in crises over the three-year evaluation period?

a. Did orientation and training on PADs and its web-based platform improve their understanding, acceptance, and capacity to access and use web-based PADs on behalf of peers when they are in crisis situations?
b. Did they feel that accessing and using a peer's web-based platform improved their de-escalation, treatment, and support experiences when peers are in crisis situations?
c. Was the PADs web-based platform sufficiently customized to address the capacity and technology infrastructure of law enforcement, first responders, medical and mental health care providers, and other stakeholders including Care Courts in accessing and using a peer's PAD?
d. Did the PADs web-based platform affect the ways that Care Courts, law enforcement, first responders, medical and mental health care providers, and other stakeholders interact with and support peers in mental health crisis situations?
e. Was access and use of the PADs web-based platform integrated into the services that mental health agencies, including Full Services Partnerships, and community stakeholders provide to peers in crisis situations?
f. Were there indicators that access, and use of the PADs web-based platform could be sustainable and under what conditions?

The following **systems level** questions have been identified as follows:

1) Were Phase 2 counties successful in aligning services, partnerships, funding, and systems in testing and demonstrating the effectiveness of the PADs web-based platform, including its acceptance and use by Care Courts?
2) Did the knowledge and experiences of implementing the PADs web-based platform in Phase 1 counties inform and improve the design, marketing, and use of the PADs web-based platform among Phase 2 counties?
3) Were precepts of peer inclusion and methods of incorporating peer perspectives established during Phase 1 relevant and effective in accessing and using the PADs web-based platform by Phase 2 counties' priority populations?
4) Were Phase 2 counties able to establish a process and plan for sustaining and replicating the access and use of the PADs web-based platform by their priority populations, and community stakeholders?

For specific evaluation methods, please see page 22 and pages 24-26.

The Budget (see Appendix pages 46-47):

Orange County is seeking to contribute $4,980,470 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for five years:

- A total of $3,405,995 (68.4% of total budget) will cover consultant and evaluation costs
- County costs total $1,574,475 (31.6% of total budget) to cover training and technical assistance, administrative costs, marketing supplies, equipment costs, salaries/benefits as well as costs associated with travel and mileage.

Note: the percentages calculated on the budget spreadsheet (see page 47) do not include County administrative costs. The dollar amounts and percentages above are inclusive of all project costs.

This project will partner with the following contractors for the implementation, training, testing and evaluation of this project (see pages 18-22 for listed Contractors in this project):

- Concepts Forward Consulting – will be the assigned Lead Project Manager and will provide case management, full project oversight, financial oversight of sub-contractors and will work closely with Commission staff
- Alpha Omega Translation – will over translation and interpretation services
- Burton Blatt Institute will perform the evaluation of this phase of the project
- Idea Engineering – will offer strategic consultation and creative direction as a full-service marketing agency (i.e. video direction and production, graphic design, translation, art production and coordination)
- Painted Brain - Peer Organization selected by counties who participated in Phase One to by providing input at stakeholder meetings representing the peer voice. Painted Brain will be instrumental in utilizing peers for this project, including outreach, education, peer representation, legislative advocacy, and training in the use of PADs platform.
- Chorus Innovations, Inc - this consultant will continue from building the secure, private, and voluntary platform where individuals can store their PADs to now testing the live platform

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations. Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability (see pages 43-45).

From: Grace Reedy
Sent: Monday, July 29, 2024 2:22 PM
To: Linda Mimms
Cc: Jigna Shah; Grace Reedy; Sandra Gallardo
Subject: RE: PAD training

Follow Up Flag: Follow up
Flag Status: Flagged

Good Afternoon Ms. Mimms:

Thank you again for your feedback regarding Orange County's request to join Phase 2 of the PADs Multi-County Collaborative Innovation Project.

As indicated, I did forward your comment to both the contractor for PADs as well as the County. I would like to take the opportunity to provide their response below:

_ _ _ _ _ _

Hello Linda,
I am happy to address your comment in two sections and through the lens of the Multi-County PADs project; a significant initiative that is setting the stage here in California to provide valuable insights into the effectiveness of PADs in reducing incarcerations and hospitalizations and promoting recovery.

Comment: PADS are not legally binding if a person in psychosis rescinds theirs, according to many lawyers we have spoken to.
In California, a PAD is protected under the same laws that govern an Advance Health Care Directive. Probate law only allows someone with the capacity to revoke their advance directive.
"Section 4695. (a) A patient having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.
(b) A patient having capacity may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke."

Comment: So why are you spending all this money on this program?
One of the best resources is SAMHSA: A Practical Guide to Psychiatric Advance Directives, which conducted extensive research on PADs. I see you are associated with Duke University, and one of the main contributors and supporters of PADs is Dr. Marvin Swartz, Professor of Psychiatry and Behavioral Sciences at Duke University. Dr. Swartz's research is also addressed in the SAMHSA guide.

Nationwide individuals facing a behavioral health crisis are often incarcerated or placed in the emergency department of a hospital. Both jails and hospitals have become makeshift behavioral health facilities. Here in California, this project will showcase how PADs are instrumental in reducing the stigma of behavioral health conditions, reducing unnecessary incarcerations and inappropriate emergency room hospitalization, and providing a gateway to recovery.

- PADs are a valuable tool in a behavioral health crisis.
- Simply having conversations about creating the PAD can prevent a future crisis.
- Planning often enhances the individual's network of support.
- A PAD is created in the individual's voice, by the individual, and with their specific preferences.
- Having preferences pre-assigned can provide tools to de-escalate a crisis and prevent hospitalization.

- Incapacity is often temporary, unlike a medical advance directive, where incapacity can be permanent or life-ending.
- PADs can assist in the transition out of in-patient care and incarceration.
- In-the-moment access to a PAD can reduce incarcerations, hospitalization, and may prevent officer-involved incidents.
- An electronic PAD can travel with an individual regardless of where they live and be available for in-the-moment crisis needs.
- Facilitating a PAD with a peer can improve outcomes in both the completion of the PAD and the reduction of further crisis.
- Our Transitional-Aged Youth, or 18-25 young adults, are seeking technology-based, in-the-moment assistance that can promote recovery.

In California, our project is so much more than just an item for the lost capacity; we seek to show improved outcomes by training law enforcement, hospitals, and crisis staff to utilize individual preferences, such as de-escalation techniques and calling a preferred contact, to assist in bringing the individual back to base-line.

Best regards.

_ _ _ _ _

Both your comment and the response above will be provided within the staff analysis. If you would like your comment to remain anonymous, please let me know and I will redact your personal information, title, organization. Otherwise, I will include your name and comment in its entirety.

Thank you,

Grace Reedy (she/her) | Innovations
Health Program Specialist II
Mental Health Services Oversight & Accountability Commission
1812 9th Street Sacramento, CA 95811
(916) 665-4196 | grace.reedy@mhsoac.ca.gov

Mental Health Services
Oversight & Accountability Commission

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at 800-273-TALK (8255) or by texting TALK to 741741.

From: Grace Reedy <Grace.Reedy@mhsoac.ca.gov>
Sent: Thursday, July 18, 2024 2:00 PM
To: Linda Mimms <lindalmimms@gmail.com>
Cc: Jigna Shah <jigna.shah@MHSOAC.CA.GOV>; Grace Reedy <grace.reedy@mhsoac.ca.gov>
Subject: RE: PAD training

Hi Linda,

Thank you for your comment. I have forwarded your comment to the PADs Contractor.

Thank you,

Grace Reedy (she/her) | Innovations
Health Program Specialist II
Mental Health Services Oversight & Accountability Commission
1812 9th Street Sacramento, CA 95811
(916) 665-4196 | grace.reedy@mhsoac.ca.gov

From: Linda Mimms <lindalmimms@gmail.com>
Sent: Thursday, July 18, 2024 1:52 PM
To: Grace Reedy <Grace.Reedy@mhsoac.ca.gov>
Subject: PAD training

PADS are not legally binding if a person in psychosis rescinds theirs according to many lawyers we have spoken to. So why are you spending all this money on this program?

Linda L. Mimms, M.A. Public Policy, Duke University
Vice Chair of the Board, Schizophrenia & Psychosis Action Alliance
Training, Technical Assistance & Communication Ad Hoc CARE Group
California SMI Coalition for CARE/Grave Disability Work Group
California Advocates for Treatment
National Shattering Silence Coalition (NSSC)
National Alliance on Mental Illness (NAMI)
lindalmimms@gmail.com
858-248-0024
www.linkedin.com/in/lindalmimms

"What you ignore, you empower."

From: Danielle Kelley <DKelley@dmh.lacounty.gov>
Sent: Tuesday, July 30, 2024 5:37 PM
To: Grace Reedy
Subject: Comment: Innovative Plan for Orange County Psychiatric Advance Directives. Phase 2

Follow Up Flag: Follow up
Flag Status: Flagged

Ms. Reed,

I am submitting my opposition to the MHSA funding of the PADs project in the amount of $4,980,470.

An Advance Directive for the psychiatric world has been recognized by the legislature as a vital component for quality and comprehensive care for patients receiving medical and mental health care.

However, this proposal has a tremendous potential for violation of patient's privacy and confidentiality. The potential for HIPAA Privacy Rule, Minimum Necessary Rule, and Security Rule, Business Agreement violations are enormous. California expands its scope of confidentiality and privacy protection for patient personal protected health information with its passage of the Confidentiality of Medical Information Act for mental health information exchanged through digital health applications. Furthermore, California courts have placed another layer of privacy protection on LPS patients with its case rulings involving LPS connected patients and safeguarding their privacy with another layer.

An Advance Health Care Directive including the Medical Durable Power of Attorney form is already created and available for distribution under the Advance Health Care Directive Forms [4700-4701] Chapter 2 added by Stats. 1999, Ch.658, Sec.39.

I oppose the use of MHSA funding for this project because the form and legislation is already established. Training is important for the form but it does not require a t budget of $4,980,470.

Sincerely,

Danielle Kelley, MSW, MSJ (c)

AGENDA ITEM 6

Action

August 22, 2024 Commission Meeting

Full Service Partnership Technical Assistance and Capacity Building

Summary:
In February, the Commission approved setting aside $20 million in Mental Health Wellness Act funds to fortify the operations and impacts of Full Service Partnerships (FSPs). FSPs are a cornerstone of the MHSA, designed to act as the bulwark against the most devastating impacts of mental illness—hospitalization, incarceration, and homelessness. The passing of Prop. 1 has placed new emphasis on the role of FSPs and strategies to measure and monitor their impact. Counties must spend 35% of BHSA funds to support FSPs, estimated at over $1B each year, in addition to BHSA housing dollars and any drawdown of federal funds. FSPs are essential and California must ensure that these investments are well spent and that programs are operating effectively.

The proposal outlined in this agenda item is designed to strengthen California's FSP programs and better align incentives with outcomes to support the implementation of Prop 1 reforms.

Background:
California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a serious mental illness often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. When executed with fidelity, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives.

Despite their potential, many FSP programs are not effectively responding to needs or achieving their anticipated outcomes. Too many FSP participants cycle through emergency hospitalizations with inconsistent care coordination between the FSP provider and hospital clinical teams. Families and clients report difficulties accessing FSP programs and understanding their capacity or availability. FSP services are not consistently expanding and contracting as an individual's needs evolve. Research indicates that clients who could potentially be served in the community are instead more likely to be served in much more costly and restrictive locked institutional settings.

Commission supported research has documented unaligned fiscal incentives that prioritize federal cost sharing over tailored care. Data reporting strategies and infrastructure do not accurately and consistently reflect access to care and outcomes achieved. There are few if any technical assistance

and training resources available to support counties and providers focused on improving their FSP investments.

In response, the Commission shall consider an initial investment in technical assistance and training to strengthen how counties design, deliver, and fund FSPs. This technical assistance will focus on strengthening their performance management, integration of FSPs into the broader continuum of care, and implementation of evidence-based and community-defined evidence practices.

Staff will return to the Commission with a second proposal to invest in related elements around workforce and data/accountability with the intent of being able to monitor the impact of the state's investment in FSPs on hospitalization, incarceration, and homelessness.

Presenter: Melissa Martin-Mollard, Chief of Research and Evaluation, MHSOAC

Enclosures (1): FSP Funding Proposal

Handouts (1): Overview of FSP Funding Proposal (presentation slides)

Proposed Motion: That the Commission approve the allocation of $10 million in Mental Health Wellness Act funds to support the capacity building and technical assistance efforts as specified in the enclosed FSP Funding Proposal.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Full Service Partnership Technical Assistance and Capacity Building Funding Proposal

California has invested billions of dollars into Full Service Partnerships since the passage of the Mental Health Services Act 20 years ago, and with the passage of Prop 1, validated their critical importance in the continuum of care. Over the next five years, an estimated $5B in BHSA funds will be invested to support FSPs and their "whatever it takes" model. This is in addition to housing dollars that can be used to support FSP partners and any federal dollars counties draw down for reimbursement. Despite these investments, FSPs are in dire need of technical assistance and capacity building to operate as effectively and efficiently as possible.

The passing of Prop 1 has placed a new spotlight on FSPs, and increased pressure on County Behavioral Health Departments to develop solutions and meet the rising tide of need. In February 2024, the Commission authorized setting aside $20 million in Mental Health Wellness Act (MHWA) funds to support transformational change in FSPs statewide. This proposal outlines the Commission's suggested approach to bring transformational change to FSPs.

The initial proposed investment of $10M focuses on technical assistance and training to strengthen how counties design, deliver, and fund FSPs. This technical assistance will focus on strengthening their performance management, integration of FSPs into the broader continuum of care, and implementation of evidence-based and community-defined evidence practices.

Detailed Funding Proposal

Despite being a "whatever it takes" model, FSPs are currently not incentivized to provide services that cannot be billed. Thus, service has become homogeneous and is losing its ability to respond to individual needs. It emphasizes treatment not recovery, thus focusing on "fixing" client deficits instead of meeting client growth goals.

An additional and related issue is that FSP providers identified a need for assistance that is specific, grounded in their peers' best practices, and appropriate for the limited time and capacity that FSP providers have. There is a strong desire for increased clarity and guidance around service delivery models, FSP levels of care, housing, and guidance on how CalAIM payment reform and Prop 1 would affect FSP funding.

The Commission proposes allocating dollars towards the scaling of value-based contracting and performance management to systematically increase service quality of FSP providers and strengthen California's behavioural health system. In addition, the proposed strategy will

strengthen efforts to provide technical assistance and training on implementing evidence-based and community-defined evidence practice to support access to and quality of services.

FUNDING: Competitive bid, $10M

Selection Strategy

The Commission seeks applications from contractors to support technical assistance and capacity building for FSPs to operate optimally. All procurements will be through a competitive bid process and will be awarded based on the following criteria and timeline. Additionally, there is an expectation that proposals will include incentives to counties to participate.

Proposals will be judged on:

- Alignment with stated focus areas
- Scope and scale of impact
- Ability to reduce disparities culturally, linguistically or for individuals with disabilities
- Dedicated capacity and resources to meet the stated goals
- Familiarity with California's behavioral health systems
- Strength of relationship with stakeholders (FSP providers, clients, families, peers, and state and county behavioral health entities)
- Potential for lasting, positive impact on the continuum of care

Background and Context

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives.

The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a "whatever it takes" approach to meeting needs – or Full Service. By supporting recovery with individuals who otherwise would be caught in a cycle of hospitalizations and incarcerations, FSPs help people develop and advance toward personal mental health goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the

Mental Health Services Act and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness—hospitalization, incarceration, and homelessness.

Despite their immense potential to reduce homelessness, incarceration and hospitalization across the state, FSPs experience challenges meeting the growing need for services.

Alignment with Transformational Change in Behavioral Health

In March, Californians passed Proposition 1, bringing modernization to the Mental Health Services Act and placing a new emphasis on the importance of FSPs. Prop 1 highlights six key areas through which to fortify and amplify the efforts and impacts of FSPs. Those areas are 1) support effective service delivery models 2) implement effective, on the ground, services for individuals with substance use disorders (SUD) 3) strengthen engagement practices to retain clients and increase service utilization 4) develop distinct levels of care to allow FSP clients to receive appropriate services in the least restrictive manner 5) provide supportive services, including clinical and non-clinical services, in the field and in outpatient settings 6) provide housing support, including connecting individuals to housing and supporting individuals in maintaining stable housing. In addition to these key areas, Prop 1 places a new emphasis on accountability and transparency to ensure funds are being used appropriately and effectively.

FSP service providers, and county behavioral health staff have been vocal in their need to receive supports in order to meet the new requirements under Prop 1. DHCS is currently in the process of establishing of a center of excellence for evidence-based practices in service delivery models. While these efforts promise to provide much needed support to counties in the implementation of effective service delivery models, there remains a lack of technical assistance and capacity building supports in other areas.

The funding streams outlined in this proposal acknowledge and respond to the goals of Prop 1 while also addressing the structural barriers that impede the ability of service providers and counties to meet these goals.

FSP Initiative Progress

To identify the current social, organizational and technical barriers impeding effective implementation of FSP services, and those threatening to impede the effective implementation of Prop 1, the Commission engaged in a two-year learning strategy and landscape analysis. Those efforts are detailed below:

Report to the Legislature: SB465 (2021) charges the Commission with biennial reporting to the legislature on the performance and impact of FSPs. Our initial report, submitted to the

legislature in February 2022, highlighted the need for capacity building, greater understanding of FSPs within the broader continuum of care, data quality and improvement efforts, further data analysis to better understand outcomes of partners, and recommendations for an investment strategy for FSPs.

Public Hearings: Two public hearings on FSPs have been held. The first was held in April 2023 and focused on the history and promise of FSP programs and included a panel presentation designed to support the Commission's understanding of the program model, the systemic challenges in meeting the need across the state, and opportunities to strengthen programs through capacity building, technical assistance, and evaluation. Panelists included Dave Pilon, one of the original designers of FSPs, a peer with lived experience with an FSP, county and provider perspectives, and a technical assistance provider.

The second public hearing was in May 2024 and hosted an FSP panel that included a representative from DHCS, technical assistance providers, and a county behavioral health director. The panel highlighted the vast potential to expand and fortify FSP service, and the need for a technical assistance and capacity building strategy to improve statewide outcomes for those eligible and/or receiving FSP services.

Community Engagement: As part of the FSP initiative, staff and technical assistance partners have done extensive community engagement to better understand the needs of counties to drive the kind of systemwide improvement necessary to move the needle on hospitalization, homelessness, and incarceration for Californians with serious mental illness. This includes: 1) conducting deep dives of current contract management practices with several counties; 2) hosting numerous listening sessions, focus groups, and interviews to better understand FSP service delivery; and 3) fielding a statewide survey of county behavioral health directors to identify ways to improve outcomes for FSP partners.

Site Visits: Staff have organized a series of site visits to be able to visit and learn from counties and providers directly. Commissioners had the opportunity in April 2023 to visit two FSP programs in Sacramento, both run by Turning Point Community Programs—Integrated Services Agency and Pathways to Success after Homelessness. The Commission heard from staff about services and support that are part of the FSP model and challenges and opportunities they see in meeting the needs of individuals referred to FSP programs.

In April 2024, staff organized a site visit to a county-run youth and TAY FSP in Butte County. During this visit staff were able meet with clinicians (including peers), a young adult client, family member of a school-aged client, and county administrative staff. We gained insight into the unique challenges that youth in FSPs face, and the multiple hats service providers to TAY and child clients must wear. We also heard first-hand from a youth who spoke to the devastating loss of community, education, and housing as a result of the Paradise fire.

In June 2024, staff coordinated site visits to Nevada and Los Angeles counties to learn more about data reporting challenges. In Los Angeles County, staff visited two FSP providers—one focused on meeting the needs of partners with SUD issues and the other with an emphasis on diverting clients from the criminal justice system.

Learning Collaboratives: In January 2020, Third Sector began a multi-year, learning collaborative with six California counties. During this time, the multi-county learning collaborative worked to standardize definitions, identify key outcomes and share recommendations for an overhaul of the current FSP data reporting system.

Technical Assistance and Capacity Building: Building on the learning from the multi-county collaborative, The Commission will convene a series of working groups, over the next year, to elicit best practice recommendations across key areas of focus for FSP providers in California. The working group strives to include county behavioral health department staff, representatives from DHCS, CBHDA, individuals with clinical or evaluation expertise in the field, and others. The learnings from this working group will then be synthesized into a draft toolkit that FSP providers can use in their work.

Concurrently, The Commission will be implementing performance management capacity building with Sacramento and Nevada counties by providing direct technical assistance to six FSP providers over the course of a year.

AGENDA ITEM 7

Action

August 22, 2024 Commission Meeting

Mental Health Student Services Act

Summary: The Commission will hear an overview of its work to support school mental health, including an update on a legislatively mandated report on the implementation of the Mental Health Student Services Act (MHSSA), results of the recent MHSSA Request for Applications, and a report out on Commission supported MHSSA Technical Assistance Teams. The presentation will include local MHSSA grant partners and students who will share information on their elementary school program, Hope Squad. Hope Squad is an evidenced based suicide prevention and mental well-being peer support program. Students are nominated by their peers as trustworthy, friendly, and approachable and provided training in peer-to-peer connection.

Background: The 2019 Budget Bill, Senate Bill 75, included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities. The Commission awards grants to incentivize partnerships who deliver school-based mental health service to students and their families, conduct outreach to identify early signs of unmet mental health needs, reduce stigma and discrimination and prevent unmet mental health needs from becoming severe and disabling. The primary goal of the MHSSA is to establish and strengthen school-based mental health partnerships between county behavioral health departments, school districts, county office of education, and charter schools. The MHSSA is part of a broader investment in California's children and youth behavioral health system. To support long-term local success in school mental health systems, will require a shared understanding across California agencies of both the systems change goals California is working toward and the metrics to measure progress.

MHSSA Legislative Report and Evaluation: The Commission is required under MHSSA to submit biennial reports to the legislature on students served and lessons learned. High level findings and recommendations will be shared with the Commission before the final report is presented for adoption. The Commission also partnered with WestEd to plan an evaluation of MHSSA which is complete and will be shared with the Commission.

MHSSA Grants: To date, there have been four grant phases that have awarded a total of $280 million to 57 counties. In the most recent phase of funding, the Commission announced MHSSA RFA 004 awardees on August 12, 2024. A total of 51 grants were awarded, totaling $25 million. Grants were awarded in four categories: Marginalized Youth (11), Sustainability (20), Universal Screening (9), and an "other" category (11) meant for applicants to identify nuanced needs relative to their population. Staff are working to execute contracts with grantees to begin program implementation.

On August 8, 2024, the MHSSA Technical Coaching Team met with Commission staff to discuss strategies for providing technical assistance to grantees. They are planning presentations for the September learning collaborative relative to Partnership Development, Program Implementation, Sustainability, and Data Collection. The Commission will soon be releasing the RFA for a Statewide Technical Assistance Coordinator to profile project management and guide the development of the statewide strategy for school-based mental health.

Presenters: Melissa Martin-Mollard, Chief of Research and Evaluation, and Riann Kopchak, Chief of Community Engagement and Grants

Enclosures: None

Handouts (2): (1) Executive Summary of the MHSSA Report to the Legislature; (2) Presentation

Motion: None

AGENDA ITEM 9

Information

July 25, 2024 Commission Meeting

Proposition 1 Implementation Follow-Up

Summary:
The passage of Proposition 1 in March of 2024 presents numerous opportunities to improve the Commission's processes and strengthen its commitment to the goals of the Behavioral Health Services Act. Proposition 1 also broadens the Commission's scope, duties, and roles, offering a unique opportunity to support the implementation of these reforms over the next few years. Navigating this transformative period will require strategic planning, innovation, and a steadfast commitment to improving behavioral health outcomes for all Californians.

At the August Commission meeting, Commissioners will receive an update on the implementation of Proposition 1, including how the Commission plans to leverage meetings, committees, subcommittees, delegated authority, onboarding, and rebranding to refine its functions and roles under the new laws.

Presenter: Kendra Zoller, Deputy Director of Legislation

Enclosures: None

Handouts: None

Proposed Motion: None

MISCELLANEOUS ENCLOSURES

August 22nd, 2024 Commission Meeting

Enclosures (4):

(1) Written General Public Comment
(2) Evaluation Dashboard
(3) Innovation Dashboard
(4) Department of Health Care Services Revenue and Expenditure Reports Status Update
(5) Rolling Calendar

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Tuesday, July 23, 2024 12:07 PM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>; Toby Ewing <Toby.Ewing@mhsoac.ca.gov>; Mark.Ghaly@chhs.ca.gov; info <info@lalafco.org>; Los Angeles County District Attorney's Office <info@da.lacounty.gov>; info@allcove.org; media@ph.lacounty.gov; jared.goldman@chhs.ca.gov
Cc: Kevin Cody <kevin@easyreadernews.com>; lisa.jacobs@scng.com; Garth Meyer <gmeyer@easyreadernews.com>; tevains@scng.com; Eleanor Manzano <cityclerk@redondo.org>; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; msemenza@cityofgardena.org; marsha@cocosouthla.org; kbradshaw@carsonca.gov; CityClerk@lacity.org; cityclerk@lawndalecity.org; athompson@cityofinglewood.org; contactcityclerk@comptoncity.org; cityclerk@longbeach.gov; executiveoffice@bos.lacounty.gov
Subject: Public Comment All Agencies - BCHDs Failure to Provide allcove Services to Disadvantaged and Health Care Professional Shortage Area

Over 80% of allcove BCHDs participants are from RB/HB/MB/Torrance/"Other" - while Disadvantaged Communities and Mental Health Professional Shortage Areas get less than 15% of allcove services. THAT'S UNFAIR. THAT'S ALSO A POTENTIAL LIABILITY TO BCHD Taxpayers if the State audits BCHD and claws back the funding. While we can never know the intent of BCHDs Board's expansion into 80% to 95% non-resident services - we can surmise that BCHD expanded its allcove service area to win a funding award. BCHD added 1.2M population to the Health District for allcove, apparently in order to secure some Disadvantaged Communities, Lower Income Areas, Non-white Areas, and Mental Health Professional Shortage Areas (MHPSAs) and score more points on the funding evaluation. BUT WHEN THE RESULTS ARE IN - BCHD SPENT THE FUNDING ON RELATIVELY HIGH INCOME, RELATIVELY WHITE AREAS WITH AMPLE MENTAL HEALTH PROFESSIONALS. MHPSAs and Disadvantaged communities carried the day for BCHD's funding request - yet - BCHDs threw them crumbs. The BCHD Board has failed and opened District taxpayers to financial liability.

Over 80% of allcove Beach Cities services are provided to Redondo Beach, Torrance, Manhattan Beach, Hermosa Beach and an unknown group of youth that may be from outside the service area of allcove.

Athens, Gardena, Harbor City, Hawthorne, Inglewood, Rancho Dominguez are areas of lower income and higher shares of non-white residents; as well as Mental Health Professional Shortage and Disadvantaged Community designations with only modest allcove resources.

SPA8	Population	HH Income < $100K (2)	% Non-white > 70% (3)	Mental Health Professional Shortage Area (HPSA) (4)	Disadvantaged Community SB 535 (5)	% of allcove Enrollment > 5% of TOTAL allcove program (6)
Athens	9,000	$ 48,824	98.8%	1	1	0.0%
Carson	90,000	$103,045	79.6%	1	1	1.0%
Gardena	60,000	$ 75,443	81.3%	1	1	0.8%
Harbor City	25,000	$ 80,245	92.0%	1	1	0.0%
Hawthorne	87,000	$ 72,298	78.0%	1	1	4.6%
Inglewood	110,000	$ 67,553	83.0%	1	1	3.4%
Rancho Dominguez	15,000	$ 73,300	81.0%	1	1	0.0%
San Pedro	86,000	$ 87,800	67.0%	1	1	1.0%
Avalon	3,700	$ 89,131	59.7%	1		0.0%
Catalina Island	300			1		0.0%
Long Beach	467,000	$ 78,995	73.0%	1		0.5%
Lawndale	33,000	$ 76,213	84.0%		1	2.1%
Lennox	22,000	$ 54,611	74.1%		1	0.0%
Wilmington	53,000	$ 55,141	96.5%		1	0.0%
El Segundo	17,000	$142,596	43.0%			0.5%
Hermosa	19,000	$149,500	27.0%			6.4%
Manhattan	36,000	$187,217	24.6%			8.2%
PVE	13,000	$224,766	37.0%			0.9%
RPV	42,000	$166,700	53.0%			2.3%
Redondo	67,000	$134,500	44.0%			39.7%
Rolling Hills	1,500	$250,003	20.0%			0.2%
RHE	8,000	$179,917	34.2%			0.7%
Torrance	145,000	$109,900	67.0%			16.5%
OTHER (out of SPA8, anonymous, unknown)						10.4%

In order to have a more "attractive" application for MHSA funding, BCHD appears to have expanded its service area from the relatively white and affluent voter-approved "residents who reside within the District" to all of LA County Health's Service Planning Area #8.

That neatly checked the mental health professional shortage areas (MHSAs), disadvantaged communities, populations with racial disparities, and ethnically diverse groups for the purpose of evaluation of funding applications.

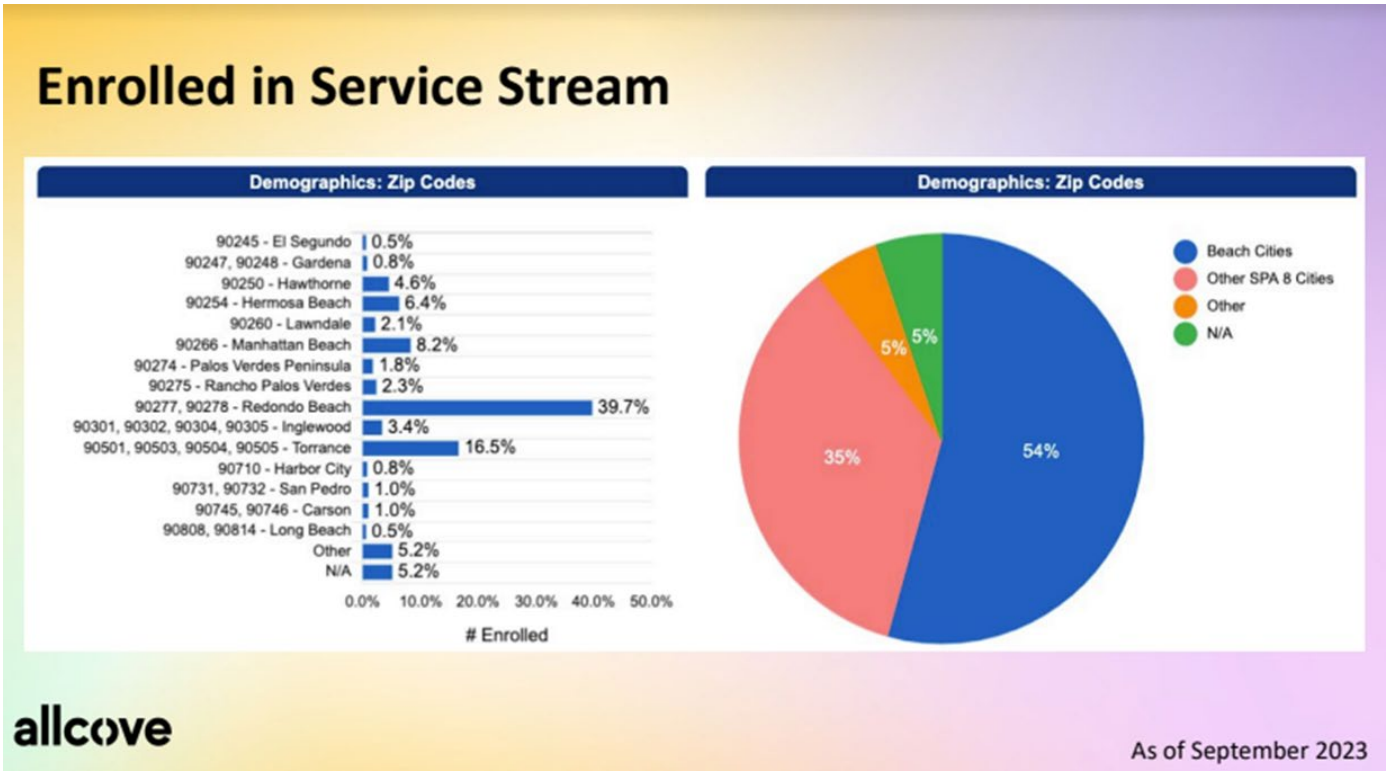
Unfortunately as the analysis shows, over 70% of allcove participation is from Redondo, Hermosa, Manhattan, and Torrance – while the the disadvantaged communities and MHSAs are catching the crumbs of BCHDs program, participation, and spending.

MHSOAC

RFA Youth-Driven Programs-001 Addendum 1
Youth-Driven Programs

5. Grant awards will be calculated based on multiple factors, including but not limited to: number of total applications received, number of applications received by track and practice model type, and, number of total individuals expected to be impacted (i.e., served) by grant applicant as a result of the grant award. Priority will be given to applicants serving communities with higher demonstrated need (e.g., mental health professional shortage areas, socio-economically disadvantaged communities, communities with populations of focus) or those which propose to reduce disparities between racial/ethnic/marginalized groups in the community.

PROVIDED BY BCHD AS THE MOST CURRENT INFORMATION AVAILABLE AS OF JUNE 4 2024 19:38 WHEN BCHD EMAILED IT.



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StopBCHD.com (StopBCHD@gmail.com) is a Neighborhood Quality-of-Life Community concerned about the quality-of-life, health, and economic damages that BCHDs 110-foot above the street, 800,000 sqft commercial development will inflict for the next 50-100 years. Our neighborhoods have been burdened since 1960 by the failed South Bay Hospital project and have not received the benefit of the voter-approved acute care public hospital since 1984.Yet we still suffer 100% of the damages and we will suffer 100% of the damages of BCHDs proposal.

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Friday, August 2, 2024 1:05 PM
To: Jane Diehl; martha.koo@bchd.org; Noel Chun; Michelle Bholat
Cc: info; executiveoffice@bos.lacounty.gov; Kevin Cody; Nils Nehrenheim; todd.loewenstein@redondo.org; paige.kaluderovic@redondo.org; Zein Obagi; scott.behrendt@redondo.org; Eleanor Manzano; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; info@achd.org; staff@csmfo.org; research@gfoa.org; MHSOAC; Toby Ewing; Mark.Ghaly@chhs.ca.gov
Subject: Public Comment All Agencies - BCHD Counsel states that BCHD faces financial insolvency

At a recent Redondo Beach Planning Commission meeting, BCHD's pricey outside counsel started throwing spaghetti at the wall to see what would stick. One of his handfuls was a claim that BCHD will be financially insolvent if it isn't allowed to violate the proposed Redondo Beach General Plan. No one should be surprised that BCHD is facing insolvency. BCHD added 1.2M people to its allcove service area in order to gain only $6.3M funding for an allcove building. Only $6.3M.

BCHD never conducted any financial analysis to determine what the cost to the District taxpayers would be from the required 30-year obligation to operate allcove services and facilities. The 30-year obligation was a requirement to accept the $6.3M. Wouldn't a prudent and competent agency compute the 30-year cost before signing the agreement? Not BCHD. And BCHD is apparently still afraid to look at the cost. Independent estimates show that BCHD accepted a $6.3M grant in return for BCHD taxpayers providing $175M in services to a 91% non-resident service area with allcove across 30-years.

On11/13/2023, BCHD admitted in a public records response it had not conducted financial analysis to estimate the cost and that current allcove funding expires in June 2026. How's that for fiscal mismanagement?

And then the BCHD pricey outside counsel made an argument about the General Plan violating the equal protection clause and the rights of BCHD. Based on BCHD's lack of analysis and accepting a $6.3M grant with a $175M tail cost, the only protection that BCHD's Board and Executives need is from themselves.

BCHD is facing an existential threat - and it is in the mirror.

Public Comment:
Redondo Beach City Council and Planning Commission
Hermosa Beach City Council

Manhattan Beach City Council
LALAFCO Board
LA County BoS
ACHD
Cal Soc of Muni Finance Officers
CFOA
MHSAOAC

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StopBCHD.com (StopBCHD@gmail.com) is a Neighborhood Quality-of-Life Community concerned about the quality-of-life, health, and economic damages that BCHDs 110-foot above the street, 800,000 sqft commercial development will inflict for the next 50-100 years. Our neighborhoods have been burdened since 1960 by the failed South Bay Hospital project and have not received the benefit of the voter-approved acute care public hospital since 1984.Yet we still suffer 100% of the damages and we will suffer 100% of the damages of BCHDs proposal.

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Saturday, August 3, 2024 8:00 AM
To: Mark.Ghaly@chhs.ca.gov; info; Los Angeles County District Attorney's Office; info@allcove.org; media@ph.lacounty.gov; jared.goldman@chhs.ca.gov; MHSOAC; Cc: Kevin Cody; lisa.jacobs@scng.com; Garth Meyer; tevains@scng.com; Eleanor Manzano; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; msemenza@cityofgardena.org; marsha@cocosouthla.org; kbradshaw@carsonca.gov; CityClerk@lacity.org; cityclerk@lawndalecity.org; athompson@cityofinglewood.org; contactcityclerk@comptoncity.org; cityclerk@longbeach.gov; executiveoffice@bos.lacounty.gov; info@redondochamber.org; info@achd.org; mayor@lacity.gov; Toby Ewing; Jane Diehl; Noel Chun; Michelle Bholat; martha.koo@bchd.org; HollyJMitchell@bos.lacounty.gov; Al.Muratsuchi@asm.ca.gov
Subject: StopBCHD.com Public Comment - All Listed Agencies - BCHD Acknowledges that it Keeps 74% of allcove Services Close to Home

The CEO of BCHD has stated that BCHD's only obligation for allcove Beach Cities services to the greater LA County Service Planning Area 8 (SPA8) is to "**make services available**".

He went even further to declare that 74% of allcove services went to Manhattan Beach, Redondo Beach, Hermosa Beach and Torrance. Those 4 cities have an average annual household income of $145,000 and are 41% non-White per Census data. The SPA8 communities that are designated as Disadvantaged and Healthcare Shortage Areas have an average annual household income of $74,000 and are 81% non-White.

DOES NO ONE SEE THE INEQUITY OF ALLOWING AN AFFLUENT HEALTH DISTRICT TO CLAIM A LARGE, DISADVANTAGED AREA IN ORDER TO GET FUNDING - AND THEN FOR THAT DISTRICT TO KEEP 74% OF THE SERVICES WITHIN 2 MILES FROM THEIR OFFICE?

ISN'T THE MHSOAC SUPPOSED TO ASSURE EQUITY? MAYBE NOT.

The plain English interpretation of all this is that BCHD will build its allcove in a largely White, largely affluent area and invite the Disadvantaged Communities and Mental Healthcare Professional Shortage Areas, non-White, and low income youth to come on down to the beach for services!

Anyone who has taken the time to read the Mental Health Services Act, its legislative intent, or the evaluation documents for the funding that BCHD received would know that Mental HPSAs and Disadvantaged Communities are the main MHSA focus.

We are truly shocked that CEO Bakaly believes that it's acceptable to direct 74% of the allcove services (and funding?) to the area within 2 miles of his office.

How can anyone believe that the MHSOAC is doing its job allowing funds to be hoarded like BCHD is doing?

We call on the Cities that are being shortchanged and the agencies with influence to bring EQUITY to allcove.

From the EasyReaderNews of the South Bay:

Opponents to the BCHD bond have argued in letters to the editor and on social media, that the bond taxes Beach City residents for services, such as allcove's, that benefit non Beach Cities residents. Opponents also argue allcove's focus on Beach Cities youth diverts county mental health funds away from more needy South Bay communities

In an interview last week, Bakaly responded to that criticism by noting 55% of the 8,000 youth visits to allcove have been from the Beach Cities youth since it opened 1.5 years ago. If Torrance is included the percentage of local youths is 74 percent. He (Bakaly) said allcove's services are also made available to greater South Bay youths because that is a requirement of its State funding.

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From: Stop BCHD <stop.bchd@gmail.com>
Sent: Saturday, August 3, 2024 3:16 PM
To: Mark.Ghaly@chhs.ca.gov; info; Los Angeles County District Attorney's Office; info@allcove.org; media@ph.lacounty.gov; jared.goldman@chhs.ca.gov; MHSOAC; Cc: Kevin Cody; lisa.jacobs@scng.com; Garth Meyer; tevains@scng.com; Eleanor Manzano; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; msemenza@cityofgardena.org; marsha@cocosouthla.org; kbradshaw@carsonca.gov; CityClerk@lacity.org; cityclerk@lawndalecity.org; athompson@cityofinglewood.org; contactcityclerk@comptoncity.org; cityclerk@longbeach.gov; executiveoffice@bos.lacounty.gov; info@redondochamber.org; info@achd.org; mayor@lacity.gov; Toby Ewing; Jane Diehl; Noel Chun; Michelle Bholat; martha.koo@bchd.org; HollyJMitchell@bos.lacounty.gov; Al.Muratsuchi@asm.ca.gov
Subject: PUBLIC COMMENT - Oppose BCHD's $30M Bond Proposition
Attachments: OPPOSE BCHD Bond Request 30M Analysis.pdf

Public Comment - all Boards, City Councils, Agencies

We received notice and official language of the BCHD Bond Measure for $30M from LA County yesterday. As BCHD's outside counsel implied at the Planning Commission, BCHD's financial situation is precarious. Specifically the counsel stated that if BCHD is not allowed to violate the proposed Redondo Beach General Plan, that BCHD may well become financially insolvent. The video of the meeting will be available soon for your own review.

SPA8 Disadvantaged Communities and Areas of Mental Healthcare Provider Shortages are getting less than 15% of the allcove services. BCHD touts its 74% usage by the District and Torrance. That is de facto inequitable based on statistical analysis. SPA8 cities should be provided their fair share of allcove services and demand the allcove building be built in the population centroid of SPA8 and not 12 blocks from the beach, creating what seems to be an intentional barrier to communities of greater color and lower income than the District.

The analysis is attached and it is also a public comment to be entered into the record of each jurisdiction.

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StopBCHD.com (StopBCHD@gmail.com) is a Neighborhood Quality-of-Life Community concerned about the quality-of-life, health, and economic damages that BCHDs 110-foot above the street, 800,000 sqft commercial development will inflict for the next 50-100 years. Our neighborhoods have been burdened since 1960 by the failed South Bay Hospital project and have not received the benefit of the voter-approved acute care public hospital since 1984.Yet we still suffer 100% of the damages and we will suffer 100% of the damages of BCHDs proposal.

BCHD BOND ISSUE OVERVIEW
(Public Comment to all Agencies)

Official bond language provided to us by the LA County Election Coordination Unit:

"BEACH CITIES HEALTH DISTRICT COMMUNITY
HEALTH AND WELLNESS MEASURE: To complete construction of the allcove youth mental health center; install water/energy conservation systems; and remove outdated facilities to create approximately 2 acres of public outdoor space for youth/older adult community wellness programs, shall Beach Cities Health District's measure authorizing $30,000,000 in bonds, at legal rates, levying approximately $3.00 per $100,000 of assessed property valuation, generating approximately $1,700,000 annually while bonds are outstanding, with financial accountability requirements, be adopted?"

From the Easy Reader News 8/1/24:
https://easyreadernews.com/bchd-board-bets-on-lucky-7-on-november-5-ballot/

"Bakaly gave the following breakdown for uses of BCHD's $30 million Community Health and Wellness Measure:

[1] $9 million for completion of the new allcove facility, facing Beryl Avenue.
[2] $8 million to tear down the old hospital, at 514 Prospect Ave.
[3] $7 million to prepare the two-acre open space for exercise programs in the center of the BCHD campus.
[4] $6 million for parking and construction improvements."

Discussion:

[1] BCHD received $6.3M from the State from Mental Health Service Act (MHSA) funding to build an allcove youth services facility. BCHD has deemed the amount insufficient and as noted, BCHD desires $9M in additional funding to complete the project.
https://www.infrastructure.buildingcalhhs.com/bhcip-data-dashboards/round-4-data-dashboard/

Acceptance of the $6.3M by BCHD required that BCHD service the entire LA County Health Department Service Planning Area 8 (SPA8) that consists of 1.4M population total and that BCHD operate the allcove facility and services for a minimum of 30-years. BCHD conducted no financial analysis of the liability prior to acceptance according to BCHD's response to a California Public Records Act (CPRA) request (Mon, Nov 13, 2023, 6:18 PM). In the same response, BCHD offered that it had operating funding of $2M through June of 2026 and no further funding.

Because BCHD has no financial analysis of the cost to the District and taxpayers of a 30-year operation of allcove, we undertook a study to estimate the cost using BCHD data, trade association data, and federal data. Our analysis shows the liability to the District of the mandatory 30-year operation to be around $175M. The analysis was conducted when BCHD was claiming the bond would include $10M in allcove costs, so the estimate is approximately $2.5M high based on the new estimate of $9M above.

https://www.stopbchd.com/post/update-allcove-s-mb-rb-hb-taxpayer-obligation-nears-175m-bchd-reveals-it-provides-free-overhead
To date, BCHD has provided no 30-year cost estimate of the mandatory allcove building and services operation.

Additionally, the allcove funding requires servicing of all of SPA8. At present, BCHD is largely ignoring cities outside of the District and Torrance where 74% of allcove resources are consumed for about 10% of the SPA8 mandatory coverage population. CEO Bakaly provided the 74% local allcove services value in the Easy Reader (8/1/24) article cite above. We currently have an active complaint filed at the MHSOAC (oversight committee for funding) and have provided a detailed analysis of BCHD's lack of servicing equity for SPA8. Our data is based on a document BCHD provided to us in late 2023.

SPA8	Population	HH Income < $100K (2)	% Non-white > 70% (3)	Mental Health Professional Shortage Area (HPSA) (4)	Disadvantaged Community SB 535 (5)	% of allcove Enrollment > 5% of TOTAL allcove program (6)
Athens	9,000	$ 48,824	98.8%	1	1	0.0%
Carson	90,000	$ 103,045	79.6%	1	1	1.0%
Gardena	60,000	$ 75,443	81.3%	1	1	0.8%
Harbor City	25,000	$ 80,245	92.0%	1	1	0.0%
Hawthorne	87,000	$ 72,298	78.0%	1	1	4.6%
Inglewood	110,000	$ 67,553	83.0%	1	1	3.4%
Rancho Dominguez	15,000	$ 73,300	81.0%	1	1	0.0%
San Pedro	86,000	$ 87,800	67.0%	1	1	1.0%
Avalon	3,700	$ 89,131	59.7%	1		0.0%
Catalina Island	300			1		0.0%
Long Beach	467,000	$ 78,995	73.0%	1		0.5%
Lawndale	33,000	$ 76,213	84.0%		1	2.1%
Lennox	22,000	$ 54,611	74.1%		1	0.0%
Wilmington	53,000	$ 55,141	96.5%		1	0.0%
El Segundo	17,000	$ 142,596	43.0%			0.5%
Hermosa	19,000	$ 149,500	27.0%			**6.4%**
Manhattan	36,000	$ 187,217	24.6%			**8.2%**
PVE	13,000	$ 224,766	37.0%			0.9%
RPV	42,000	$ 166,700	53.0%			2.3%
Redondo	67,000	$ 134,500	44.0%			**39.7%**
Rolling Hills	1,500	$ 250,003	20.0%			0.2%
RHE	8,000	$ 179,917	34.2%			0.7%
Torrance	145,000	$ 109,900	67.0%			**16.5%**
OTHER (out of SPA8, anonymous, unknown)						**10.4%**

We find it highly inequitable that BCHD has accepted MHSA funding for allcove for all of SPA8, yet services 74% HB/RB/MB/Torrance while cities with mental healthcare professional shortages and

disadvantaged community designations receive on 14% of allcove Beach Cities services. Bakaly explained in the same Easy Reader article that "allcove's services are also made available to greater South Bay youths because that is a requirement of its State funding." When a facility is built 12 blocks from the ocean in Redondo Beach and the overwhelming majority of the service area is miles to the east, it is clear that BCHD is not making any good faith effort to provide service to all of SPA8 and we have made that case.

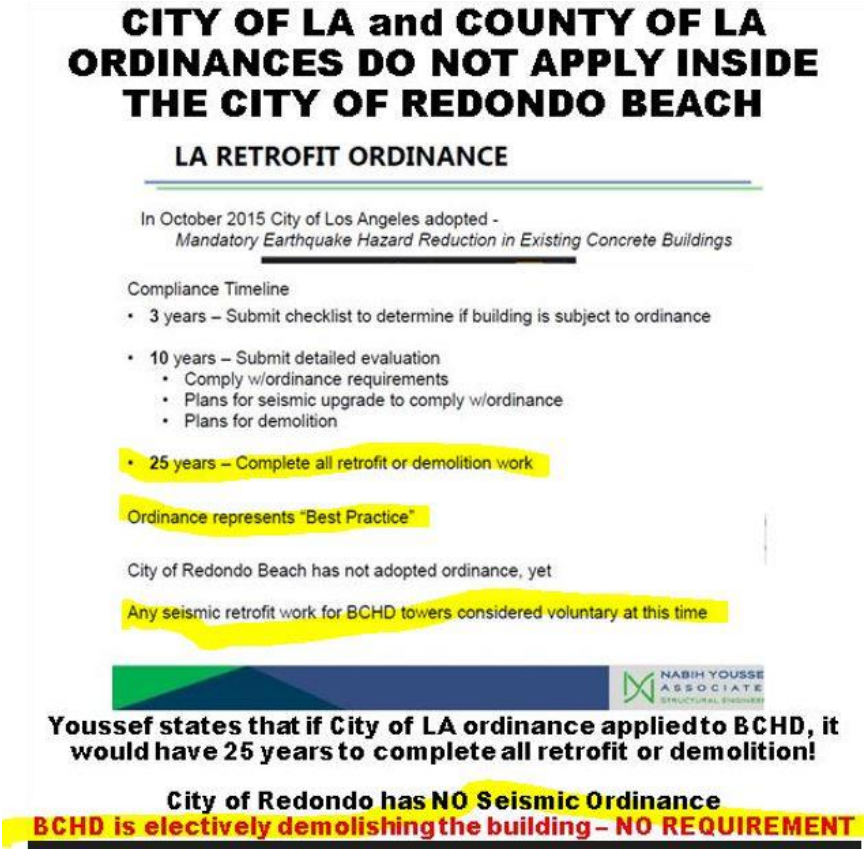
Per the BCHD website (https://www.bchd.org/allcovebeachcities), "SPA8 includes: SPA 8 serves the communities of Athens, Avalon, Carson, Catalina Island, El Segundo, Gardena, Harbor City, Hawthorne, Inglewood, Lawndale, Lennox, Long Beach, Hermosa Beach, Manhattan Beach, Palos Verdes Estates, Rancho Dominguez, Rancho Palos Verdes, Redondo Beach, Rolling Hills, Rolling Hills Estates, San Pedro, Torrance, Wilmington and others." Analysis using Census data shows that 91% of SPA8 is outside of the District.

We are concerned that BCHD is not faithfully executing its obligation to service SPA8 with allcove services and that the roughly $175M liability for 30-year operation is unreasonable to be funded by the District and can result in bankruptcy or court ordered property tax assessments. BCHD intends to get more grants, however, undertaking a 30-year obligation of $175M in order to gain $6.3M in grant funds demonstrates the impact of the District's lack of analysis.

As structured currently with 30-year operations requirements for LA County SPA8, allcove appears as a financial existential threat to the existence of the District due to its magnitude and lack of long term funding. According to BCHD (https://bchd.blob.core.windows.net/docs/bchd/finance/BCHD_ACFR_FY22-23%20Final.pdf) on page 76/90, the total asset value of the District is only $55,810,959 or less than 1/3rd the liability faced with allcove Beach Cities.

[2] BCHD's plan to demolish the hospital does not appear to be based on consultant facts, but rather, on forcing taxpayers to accept the costs in order to reduce the cost burden of PMB LLC, a 100% private company that BCHD has contracted with to build, own and operate an assisted living for up to 95 years on 3 acres of the campus.

BCHD's first seismic consultant, Youssef Assoc., provided analysis stating that the building is similar to all other 1960/1970 buildings and in a sufficient earthquake, could collapse. However, they went on to be very clear that there is no requirement for any retrofit action at this time. "Best Practice" is to analyze the building (completed) and either retrofit or demolish as needed before the end of a 25-year continued use period. The slide below is provided from a BCHD Community Working Group presentation from 1/16/2018 by Youssef Assoc. and it clearly lays out the "best practice".



BCHD spent more taxpayer funding on additional opinions, probably to bolster the case for its desire to demolish the building. The second seismic firm, ImageCat LLC made a fuzzy statement about what it believes most commercial lenders and owners would find acceptable and reinforces that no prediction of magnitude, location or timing of earthquakes is possible. Had either Youssef or ImageCat deemed the building unsafe, then according to best practice, demolition or retrofit would have been REQUIRED. Neither made that statement or conclusion.

From ImageCat:
"The 'status quo' alternative presents no upfront (immediate) costs or loss of service and income to BCHD, such as those that would result from demolition or retrofit construction. However, this exposes BCHD to significant levels of risk in terms of building damage and downtime losses and potential liability for loss of life, should an earthquake occur. The building damage, downtime, and probability of collapse estimates with 10% probability of exceedance in the next 3 to 5 years are basically close to what would be expected, and deemed acceptable by most commercial lenders and institutional owners, from new buildings over a full lifetime (i.e., a 50-year exposure period).

At the present time, it is not possible to predict specific dates and locations of future earthquakes. The models of the United States Geological Survey (USGS) predict how frequently the ground will shake with any given level of intensity over the long term. In the USGS model, the probability of shaking levels that cause high levels of damage or structural collapse are time invariant, but the length of the exposure window affect the probability. Increasing the window of exposure means there is greater opportunity for a large earthquake to occur and damage the property. The change in probabilities is incremental, rather than dramatic."

[2+3+4] The $21M in bond proceeds to be used by BCHD for demolition of the 514 N. Prospect Building, creation of green space from the resulting damages of demolition, and creation of more parking is a cost that was the responsibility of the developer, PMB LLC. BCHD's investment bankers (Cain Bros) were clear in every communication to the public that this was not a taxpayer cost. From the Cain Bros. presentation to BCHD of 9/28/2022. As can be seen, these $21M in costs were represented to the public as developer tenant costs and NOT taxpayer costs. BCHD is simply attempting to shift the costs to taxpayers and provide a $21M windfall to the developer, PMB LLC. Note that the only issue subject to change is the 2-acre green space, not the demolition or parking.

- BCHD will lease approximately 3-acres of land to PMB/Watermark Joint Venture ("Tenant") for an initial term of 65-years with two 15-year extensions
- Tenant will develop, own and maintain the RCFE Building consisting of approximately:
  - 240,000 sf licensed as an RCFE ("Facility"), and
  - 33,000 sf for BCHD allcove Youth Wellness, PACE and Community Services ("Landlord Designated Space")
- Tenant will also develop 2-acre open space lawn (*prelim. and subject to change*) and 86-surface parking spaces for the District on land that is not included in the Ground Lease
- Tenant will also be responsible for demolition of the 514 Building

Conclusion – allcove $9M Funding:

Due to BCHD's lack of analysis, it entered into the allcove Beach Cities financial existential threat to the District. BCHD failed to recognize the vast magnitude of a 30-year "must operate" obligation without secure, long term funding. BCHD's funding for allcove expires in June 2026. The 30-year period does not begin until completion of the building. The grant was only $6.3M.

Further, BCHD's lack of analysis of building costs led to BCHD accepting the $6.3M funding that was clearly insufficient for BCHD's determined activity of building construction. If it were adequate, BCHD would not be seeking an additional $9M from District taxpayers.

Since allcove is required to service Los Angeles County Department of Health Service Planning Area 8 (SPA8), it is required to service a 91% District non-resident service area. The obligation for the $9M does not rest with District taxpayers.

Conclusion – Demolition, Greenspace, Parking $21M Funding:

There is no imminent threat of collapse of damage to the 514 N Prospect Ave Hospital building. At least two seismic engineering firms have examined the building and neither determined it was imminently threatened – instead, the change in risk is incremental rather than dramatic. Further, Youssef Assoc. provided that "best practice" would allow 25 years continued use. ImageCat made statements about what "some" owners would consider reasonable and made the intuitively obvious statement that longer time periods afford a greater probability for an event, however, this cannot be forecasted.

The BCHD Board and Executives, the least qualified parties, have decided to demolish against “best practice”.

Even if demolition were required (it is not per “best practice”), the responsibility lies with the developer tenant of the massive BCHD proposed 100% private development on 3 acres of the Public site per the many Cain Bros. presentations on the topic. The development is being built for the expected use of 80% non-resident tenants by zip code of tenant origin according to BCHD’s consultant MDS’s study, and therefore it too is not the responsibility of District taxpayers. The obligation for the $21M does not rest with District taxpayers.

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Monday, August 5, 2024 9:21 AM
To: Mark.Ghaly@chhs.ca.gov; info; Los Angeles County District Attorney's Office; info@allcove.org; media@ph.lacounty.gov; jared.goldman@chhs.ca.gov; MHSOAC; Eleanor Manzano; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; msemenza@cityofgardena.org; marsha@cocosouthla.org; kbradshaw@carsonca.gov; CityClerk@lacity.org; cityclerk@lawndalecity.org; athompson@cityofinglewood.org; contactcityclerk@comptoncity.org; cityclerk@longbeach.gov; executiveoffice@bos.lacounty.gov; info@redondochamber.org; info@achd.org; mayor@lacity.gov; Toby Ewing; Al.Muratsuchi@asm.ca.gov
Subject: Public Comment - Beach Cities Health District (BCHD) Election - For the public Record All Agencies

LA Times Op/Ed on Upcoming BCHD Elections in November

Soon we'll be voting for federal, state and local candidates and measures. It's easy to overlook the smaller, local agencies like Beach Cities Health District (BCHD). BCHD has two votes on the ballot this fall; the election of three Board members and a $30M taxpayer indebtedness bond measure. There's one very serious BCHD liability issue that you've never heard about, but that you should consider when deciding what Board members to elect and whether or not to let BCHD into your pockets.

BCHD gained State funding from the mental health "millionaire's tax" to build the allcove youth mental health center in Redondo Beach. What BCHD never told District taxpayers was that BCHD's funding contract included: 1) a requirement to operate the allcove building and services for 30 years, 2) a requirement to service all of Los Angeles County Health's Service Planning Area 8 (SPA8), 3) that SPA8 represents a population of 1.4M from Catalina Island to Long Beach to the LAX area, and 4) the estimated $175M District taxpayer-funded price tag of allcove services across the 30 years.

As you consider whether to re-elect any Board members or to fork over $30M, consider the fiscal mess of the District's Board and Management. The Board has stuck you with a 30-year, 91% non-resident service area program and it wants your to fund a $30M bond that includes demolition, greenspace, and parking that their 100% private Healthy Living Campus developer pledged to pay. My advice would be to dump the current Board members and withhold the $30M until BCHD gets its fiscal house in order.

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StopBCHD.com (StopBCHD@gmail.com) is a Neighborhood Quality-of-Life Community concerned about the quality-of-life, health, and economic damages that BCHDs 110-foot above the street, 800,000 sqft commercial development will inflict for the next 50-100 years. Our neighborhoods have been burdened since 1960 by the failed South Bay Hospital project and have not received the benefit of the voter-approved acute care public hospital since 1984.Yet we still suffer 100% of the damages and we will suffer 100% of the damages of BCHDs proposal.

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Wednesday, August 7, 2024 12:46 PM
To: Mark.Ghaly@chhs.ca.gov; info; Los Angeles County District Attorney's Office; info@allcove.org; media@ph.lacounty.gov; jared.goldman@chhs.ca.gov; MHSOAC; Cc: Kevin Cody; lisa.jacobs@scng.com; Garth Meyer; tevains@scng.com; Eleanor Manzano; cityclerk@hermosabeach.gov; cityclerk@manhattanbeach.gov; msemenza@cityofgardena.org; marsha@cocosouthla.org; kbradshaw@carsonca.gov; CityClerk@lacity.org; cityclerk@lawndalecity.org; athompson@cityofinglewood.org; contactcityclerk@comptoncity.org; cityclerk@longbeach.gov; executiveoffice@bos.lacounty.gov; info@redondochamber.org; info@achd.org; mayor@lacity.gov; Toby Ewing; Jane Diehl; Noel Chun; Michelle Bholat; martha.koo@bchd.org; HollyJMitchell@bos.lacounty.gov; Al.Muratsuchi@asm.ca.gov; letters@latimes.com; opinion@scng.com
Subject: Public Comment: Required allcove services to LA County SPA8 and the Marginalization of "The 14"

After several contacts with SPA8 cities, it seems clear that BCHD is not making sufficient efforts to service what we have now dubbed "**The 14**".

The 14 are the 14 cities in SPA8 that have either mental Heathcare Professional Shortage Areas (mHSPA) or Disadvantaged Community (DC) status. The demographics of **The 14** and very different from the area where 74% of the BCHD allcove resources are being delivered. **The 14** are Athens, Carson, Gardena, Harbor City, Hawthorne, Inglewood, Rancho Dominguez, San Pedro, Avalon, Catalina Island, Long Beach, Lawndale, Lennox, and Wilmington. The first 8 cities are designated as both mHPSA and DC.The remaining cities are either mHPSA or DG.

	Avg HH Income	% of SPA8	% of allcove	% non-White	% White (100%-non White)	
RB/HB/MB/Torrance	$ 145,279	19%	74.0%	40.7%	59.4%	The 4 primary recipients of allcove
"THE 14" HPSA/DC	$ 74,046	76%	13.4%	80.6%	19.4%	The SPA8 cities that are CA-designa Communities and/or Mental Health Shortage Areas

Based on BCHD's own allcove delivery statistics, 74% of services are delivered to the District + Torrance. BCHD chosen ones have an average income level that is nearly TWICE that of **The 14**, and are a White population that is THREE times that of **The 14**.

The time for BCHD's current allcove delivery philosophy must end.

GRAB AN UBER AND COME ON DOWN TO THE BEACH FOR YOUR ALLCOVE YOUTH MENTAL HEALTH SERVICES!

Typical rideshare cost from Lawndale High to BCHD is $35 roundtrip (RT). Long Beach Poly High to BCHD is $60RT. Carson High to BCHD is $50 RT. These costs are CLEAR BARRIERS to mHSPA and DC participation in SPA8.

BCHD's current prioritization of program funds is not ethical nor appropriate for service delivery of grant funding for SPA8. BCHD is obligated to deliver these services for 30-years based on its State funding

agreement. This cannot be the inequitable method of delivery for decades and multiple generations of youth.

We are also providing a link to the Lawndale City Council meeting where it was clear that our effort to raise awareness within SPA8 is paying off. We thank Lawndale for getting involved in equitable funding distribution.

At a minimum, BCHD needs to provide more outreach, gain population-proportionate involvement, and provide transportation if it insists on providing 74% of allcove services to a non-representative area of SPA8. **The 14** cannot continue to be marginalized by BCHD's allcove program. Undoubtedly, the youth of **The 14** suffer from untreated mental health afflictions at a HIGHER RATE than the 74% services delivery area chosen by BCHD's Board and Executive Management.

https://youtu.be/UyZ6D0HVs1E?t=6323

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From: Stop BCHD <stop.bchd@gmail.com>
Sent: Wednesday, August 7, 2024 2:03 PM
To: Mark.Ghaly@chhs.ca.gov; jared.goldman@chhs.ca.gov; MHSOAC; Toby Ewing
Subject: Fwd: Public Comment: Required allcove services to LA County SPA8 and the Marginalization of "The 14"

BCHD is asserting in a recent Easy Reader News story that it was required to add service to all of SPA8 as terms of the funding agreement from MHSA. We see no evidence of that in the transaction documents. BCHD also seems to imply that it has no service provision measures to adhere to, and that merely keeping the door open to youth 12-25 from Long Beach for example is sufficient. Long Beach is an expensive $50-80 Uber round trip, which is a non-started for disadvantaged youth.

The residents of SPA8 deserve clarification of how MHSOAC is going to measure and enforce the equitable distribution of resources from allcove Beach Cities. After all, the District is less than 9% of the overall population of SPA8.

Your response is sought in this matter. This is also a Public Comment as well. Thank you.

---------- Forwarded message ---------
From: **Stop BCHD** <stop.bchd@gmail.com>
Date: Wed, Aug 7, 2024 at 12:46 PM
Subject: Public Comment: Required allcove services to LA County SPA8 and the Marginalization of "The 14"
To: <Mark.Ghaly@chhs.ca.gov>, info <info@lalafco.org>, Los Angeles County District Attorney's Office <info@da.lacounty.gov>, <info@allcove.org>, <media@ph.lacounty.gov>, <jared.goldman@chhs.ca.gov>, MHSOAC <MHSOAC@mhsoac.ca.gov>, Cc: Kevin Cody <kevin@easyreadernews.com>, <lisa.jacobs@scng.com>, Garth Meyer <gmeyer@easyreadernews.com>, <tevains@scng.com>, Eleanor Manzano <cityclerk@redondo.org>, <cityclerk@hermosabeach.gov>, <cityclerk@manhattanbeach.gov>, <msemenza@cityofgardena.org>, <marsha@cocosouthla.org>, <kbradshaw@carsonca.gov>, <CityClerk@lacity.org>, <cityclerk@lawndalecity.org>, <athompson@cityofinglewood.org>, <contactcityclerk@comptoncity.org>, <cityclerk@longbeach.gov>, <executiveoffice@bos.lacounty.gov>, <info@redondochamber.org>, <info@achd.org>, <mayor@lacity.gov>, <Toby.Ewing@mhsoac.ca.gov>, Jane Diehl <jane.diehl@bchd.org>, Noel Chun <noel.chun@bchd.org>, Michelle Bholat <michelle.bholat@bchd.org>, <martha.koo@bchd.org>, <HollyJMitchell@bos.lacounty.gov>, <Al.Muratsuchi@asm.ca.gov>, <letters@latimes.com>, <opinion@scng.com>

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https://youtu.be/UyZ6D0HVs1E?t=6323

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From: Stop BCHD <stop.bchd@gmail.com>
Sent: Sunday, August 11, 2024 9:18 PM
To: Mark.Ghaly@chhs.ca.gov; info <info@lalafco.org>; info@allcove.org; jared.goldman@chhs.ca.gov; MHSOAC <MHSOAC@mhsoac.ca.gov>; Toby Ewing <Toby.Ewing@mhsoac.ca.gov>; executiveoffice@bos.lacounty.gov
Subject: Complaint to State Auditor Office and Request for BCHD Audit as a High Risk entity under GOV § 8546.10

Public Comment - LA County BoS, LALAFCO Board, MHSOAC, CHHS

StopBCHD.com found that there is no alternative other than to submit a complaint regarding BCHDs contract actions for allcove Beach Cities regarding the $6.3M BHCIP Round 4 grant. The complaint is a request for a State Auditor investigation of the special district, Beach Cities Health District in Redondo Beach under GOV § 8546.10 based on the 1) The District failing to analyze the cost obligation of a 30-year must-serve agreement for the allcove building and services; 2) The District incurring an estimated $175M liability across the 30-year required must-serve operation for SPA8 - a service area of 91% non-residents of the District, 3) The District's outside counsel represented at Redondo Beach Planning Commission that BCHD would financially insolvent if not allowed to violate the conditions of the draft Redondo Beach General Plan, and 4) The District's current $55M net asset value and $175M allcove obligation result in a "paper" default of the District.

The investigation is confidential as we understand it and exhibits were presented in our filing.
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From: Stop BCHD <stop.bchd@gmail.com>
Sent: Monday, August 12, 2024 10:17 PM
To: rlundy@health-law.com; rmiller@health-law.com; Mark.Ghaly@chhs.ca.gov; info <info@lalafco.org>; info@allcove.org; jared.goldman@chhs.ca.gov; MHSOAC <MHSOAC@mhsoac.ca.gov>; Toby Ewing <Toby.Ewing@mhsoac.ca.gov>; executiveoffice@bos.lacounty.gov; Eleanor Manzano <cityclerk@redondo.org>; Jane Diehl <jane.diehl@bchd.org>; Michelle Bholat <michelle.bholat@bchd.org>
Subject: Fwd: CPRA Fwd: BCHD has no obligation to provide allcove to SPA8

We are very concerned that BCHD's purported claims of racial and geographic equity in allcove services were false claims made only to minority-wash BCHD's white and affluent District. As all are now aware, 74% of allcove services are going to MB/HB/RB/Torrance (19% of SPA8) while under 14% of allcove services are going to the 14 underserved cities that total 80% of SPA8. That 80% of SPA8 contains all the disadvantaged communities and mental HSPA communities. How can this be allowed by MHAOAC? BCHD is clearly in violation of the letter of their claims for funding.

BCHD appears to be deliberately avoiding any significant level of allcove service to the underserved areas. There is no other statistically plausible reason that 74% of services could be going to a group of cities with double the HH income and 3-times the white populations than the appropriate target areas requiring racial and economic equity. It certainly appears that the statistics support racism in allcove service delivery by BCHD on their face.

Perhaps the LA Times is a better path to assuring equity, since so far, the State is sitting back watching.

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Public Comment: MHSOAC, LA County BoS, LALAFCO, CHHS, Redondo Beach Council and Planning Commission

---------- Forwarded message ---------
From: **PRR** <PRR@bchd.org>
Date: Mon, Aug 12, 2024 at 8:24 PM
Subject: RE: CPRA Fwd: BCHD has no obligation to provide allcove to SPA8
To: Stop BCHD <stop.bchd@gmail.com>
Cc: PRR <PRR@bchd.org>

Dear Resident,

Please see below (in red) for the District's response to your public records request received 8/1/24 that reads:

Addition. BCHD published: REDONDO BEACH, Calif. – (May 20, 2023) Beach Cities Health District (BCHD) has been awarded $6.3 million in grant funding from the California Department of Health Care Services' (DHCS) Behavioral Health Continuum Infrastructure Program (BHCIP). This statewide program supports behavioral health infrastructure projects, providing new opportunities to address gaps in mental health services.

This grant is specifically for new construction of allcove Beach Cities, a youth wellness center in Redondo Beach, serving young people ages 12-25 in the county's Service Planning Area (SPA) 8, and comes through the BHCIP Round 4: Children and Youth grants."

(1) CPRA REQUEST: Provide a contract document that binds BCHD to provide allcove services to SPA8.

(2) Provide the application materials from BCHD to BHCIP Round 4 - IF - they include a proposal by BCHD to service SPA8

1. Please see attached responsive contract document: Exhibit A, Section 1. General and Section 4. Grantee Responsibilities.
2. Please see responsive application material for BHCIP 4 paragraph 8.

Please note that if records you are seeking do not exist, BCHD has no obligation to create new records, or to obtain records from other sources, unless those sources are considered "prepared, owned, used by, or retained by" by the District.

If you believe we have not correctly interpreted your request, please resubmit your request with a description of the identifiable record or records that you are seeking.

Please note that the District may not respond to questions or comments included with your request that are not themselves requests for identifiable public records under the California Public Records Act. The lack of response by the District to any such questions or comments, including follow-up questions and comments, is not an indication of the District's position on any topic or item, and should not be presented as such to any person.

Thank you.

From: Stop BCHD <stop.bchd@gmail.com>
Sent: Thursday, August 1, 2024 5:12 PM
To: PRR <PRR@bchd.org>
Subject: Re: CPRA Fwd: BCHD has no obligation to provide allcove to SPA8

Addition. BCHD published: REDONDO BEACH, Calif. – (May 20, 2023) Beach Cities Health District (BCHD) has been awarded $6.3 million in grant funding from the California Department of Health Care Services' (DHCS) Behavioral Health Continuum Infrastructure Program (BHCIP). This statewide program supports behavioral health infrastructure projects, providing new opportunities to address gaps in mental health services.

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(2) Provide the application materials from BCHD to BHCIP Round 4 - IF - they include a proposal by BCHD to service SPA8

On Thu, Aug 1, 2024 at 3:01 PM Stop BCHD <stop.bchd@gmail.com> wrote:

> BCHD continually claims that allcove services SPA8, however, BCHD's application for allcove funding provided by BCHD in a CPRA response (12/7/21) contained no such proposal for the $2M MHSA funding.
>
> Further, BCHD's contemporaneous press release made no mention of SPA8 either.
>
> CPRA REQUEST: Provide a contract document that binds BCHD to provide allcove services to SPA8.

---------- Forwarded message ---------
From: **Stop BCHD** <stop.bchd@gmail.com>
Date: Thu, Aug 1, 2024 at 2:48 PM
Subject: BCHD has no obligation to provide allcove to SPA8
To: <rmiller@health-law.com>, <rlundy@health-law.com>

BCHD's application for the $2M allcove operating funding as provided subject to CPRA demonstrates no obligation or intent to service SPA8.

BCHD's contemporaneous press release from March 9, 2022 makes no mention of the 1.4M population SPA8.

It appears that BCHD has misled the District taxpayers by claiming that allcove is an SPA8 service area project on its webpage https://www.bchd.org/allcovebeachcities

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Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 4

Funds Spent Since the May 2024 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
22MHSOAC050	$ 165,000.00
23MHSOAC018	$ 0.00
TOTAL	**$ 165,000.00**

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Melissa Martin-Mallard
Active Dates: 07/01/21 - 06/30/27
Total Contract Amount: $7,544,350.00
Total Spent: $4,244,350

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	Complete	06/1/2024	No
Quarterly Progress Reports	In Progress	9/30/2024	Yes
Quarterly Progress Reports	Not Started	12/31/2024	No
Quarterly Progress Reports	Not Started	3/21/2025	No
Quarterly Progress Reports	Not Started	6/30/2025	No
Quarterly Progress Reports	Not Started	9/30/2025	No

Quarterly Progress Reports	Not Started	12/31/2025	No
Quarterly Progress Reports	Not Started	3/31/2026	No
Quarterly Progress Reports	Not Started	6/30/2026	No
Quarterly Progress Reports	Not Started	9/20/2026	No
Quarterly Progress Reports	Not Started	12/31/2026	No
Quarterly Progress Reports	Not Started	3/31/2027	No
Quarterly Progress Reports	Not Started	6/1/2027	No

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $650,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Complete	December 15, 2023	No
School Mental Health Metrics	In Progress	June 15, 2024	No
Evaluation Plan (draft and final)	In Progress	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	In Progress	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete In Progress	September 15, 2023 January 15, 2024 June 15, 2024	No

Mental Health Services
Oversight & Accountability Commission

Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $450,000.00

This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

Deliverable	Status	Due Date	Change
Community Engagement Plan (draft and final)	Complete	August 31, 2023 September 30, 2023	No
Statewide Survey (draft and final)	Complete	October 31, 2023 December 31, 2023	No
Progress Reports (#1 and #2)	#1 Complete #2 Complete	October 31, 2023 March 31, 2024	No
Final Report (draft and final)	Complete	March 31, 2024 June 28, 2024	Yes

The Regents of the University of California, San Francisco:: Universal Screening Project (23MHSOAC018)

MHSOAC Staff: Kali Patterson

Active Dates: 12/12/23 -12/31/24

Total Contract Amount: $160,000

Total Spent: $10,000

The project will support the Commission in conducting research on the subject of universal mental health screening for children and youth and conduct a landscape analysis to understand universal mental health screening policies and practices for children and youth in California. Doing so will allow the Commission, as part of its required legislative Report, to develop recommendations to improve universal screening of students in California schools.

Deliverable	Status	Due Date	Change
Survey Tool	Complete	02/01/2024	No
Literature Review Report	Complete	02/01/2024	No
Project Support and Consult			No
a. Workplan	Complete	1/15/2024	
b. Meetings and Interviews	Complete	1/15/2024	
c. Analysis and Summary	Complete	4/30/2024	
Landscape Analysis Report	In Progress	6/30/2024	No
a. Draft Report		7/31/2024	
b. Final Report			

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

August 2024

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	2	1	**3**
Participating Counties (unduplicated)	2	1	**3**
Dollars Requested	$5,980,470	$999,978	**$6,980,448**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)
FY 2022-2023	31	31	$354,562,909	26 (44%)
FY 2023-2024	15	15	$197,481,034	13 (22%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2024-2025	1	1	$910,906	1

INNOVATION PROJECT DETAILS

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Orange	Community Program Planning – Extension Request	$1,000,000	5 Years	7/17/2024	7/30/2024
Under Final Review	Orange	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$4,980,470	5 Years	7/11/2024	7/17/2024

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Shasta	Level Up NorCal: Supporting Community-Driven Practices for Health Equity	$999,978	2 Years	4/26/2024	Pending

APPROVED PROJECTS (FY 24-25)			
County		Funding Amount	Approval Date
Sierra	Semi-Statewide Enterprise Health Record Multi County Collaborative	$910,906	7/25/2024

DHCS Status Chart of County RERs Received
August 22, 2024, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated August 2, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2022-2023 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2021-22 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DHCS Status Chart of County RERs Received
August 22, 2024, Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Alameda	1/31/2023	2/6/2023	2/7/2023	1/30/2024	1/31/2024	2/14/2024
Alpine	4/14/2023		4/17/2023	7/30/2024		
Amador	1/31/2023	2/7/2023	2/17/2023	2/8/2024	2/8/2024; 2/14/24	2/16/2024
Berkeley City	1/31/2023	2/2/2023	2/7/2023	1/31/2024	2/2/2023	2/6/2024
Butte						
Calaveras	1/27/2023		2/7/2023	1/31/2024	2/2/2024	2/5/2024
Colusa	4/3/2023	4/4/2023	5/11/2023	3/15/2024	3/20/2024	4/2/2024
Contra Costa	1/30/2023		2/1/2023	2/13/2024	2/14/2024	2/15/2024
Del Norte	1/30/2023		2/7/2023	1/30/2024	1/31/2024; 2/1/24	2/5/2024
El Dorado	2/24/2023		2/28/2023	1/30/2024	1/30/2024	1/30/2024
Fresno	1/31/2023	2/2/2023	2/10/2023	1/29/2024	1/30/2024	2/1/2024
Glenn	12/14/2023	12/21/2023	2/16/2024			
Humboldt	1/31/2023		2/2/2023	1/30/2024	1/31/2024	2/2/2024
Imperial	1/20/2023	1/23/2023	2/1/2023	1/19/2024	1/24/2024; 1/30/24	2/7/2024
Inyo	5/19/2023		8/16/2023	5/28/2024	5/29/2024	
Kern	1/31/2023	2/1/2023	2/15/2023	2/2/2024	2/9/2024	2/23/2024
Kings	1/10/2023	1/19/2023	2/14/2023	2/8/2024	2/14/2024	2/16/2024
Lake	1/31/2023		2/1/2023	5/8/2024	5/8/2024	5/9/2024
Lassen	2/8/2023	2/9/2023	2/14/2023	2/29/2024	2/29/2024	3/5/2024
Los Angeles	1/31/2023	2/2/2023	2/17/2023	2/5/2024	2/6/2024	2/16/2024
Madera	2/8/2023	2/9/2023	2/14/2023	3/22/2024		3/29/2024

DHCS Status Chart of County RERs Received
August 22, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Marin	1/30/2023	1/31/2023	2/3/2023	1/31/2024	2/2/2024	2/5/2024
Mariposa	4/19/2023	4/20/2023	4/21/2023	2/7/2024	2/15/2024	2/15/2024
Mendocino	1/31/2023		2/2/2023	1/31/2024	2/5/2024	2/15/2024
Merced	1/19/2023		1/23/2023	1/18/2024	1/19/2024	1/23/2024
Modoc	3/23/23	4/4/2023	4/5/2023	5/6/2024	5/8/2024	5/13/2024
Mono	1/31/2023		2/2/2023	1/31/2024	2/5/2024	
Monterey	1/31/2023	2/2/2023	2/2/2023	1/31/2024	2/1/2024	2/6/2024
Napa	1/31/2023	2/1/2023	2/13/2023	2/6/2024	2/9/2024	3/11/2024
Nevada	1/31/2023	2/1/2023	2/2/2023	1/31/2024	2/9/2024	2/14/2024
Orange	1/31/2023		2/1/2023	1/31/2024	2/7/2024	2/15/2024
Placer	1/31/2023	2/1/2023	2/14/2023	1/31/2024	n/a	2/7/2024
Plumas	2/14/2023	2/15/2023	2/21/2023	2/9/2024	2/9/2024	2/15/2024
Riverside	1/31/2023	2/1/2023	2/15/2023	2/1/2024	2/8/2024	2/21/2024
Sacramento	1/25/2023	1/26/2023	1/27/2023	1/31/2024	2/14/2024	2/23/2024
San Benito	5/10/2023	5/11/2023	5/25/2023	3/18/2024	3/18/2024	3/22/2024
San Bernardino	1/31/2023		2/6/2023	1/31/2024	2/12/2024	2/21/2024
San Diego	1/31/2023	1/31/2023	2/14/2023	1/30/2024	2/5/2024	2/14/2024
San Francisco	1/31/2023	2/1/2023	2/16/2023	1/31/2024	2/8/2024	
San Joaquin	1/31/2023		2/1/2023	2/22/2024	3/7/2024	3/27/2024
San Luis Obispo	12/30/2023	1/6/2023	1/19/2023	1/25/2024	2/8/2024	2/14/2024
San Mateo	3/6/2023	3/24/2023	4/3/2023	2/16/2024	2/22/2024	4/9/2024
Santa Barbara	12/23/2023	2/7/2023	2/15/2023	1/30/2024	2/9/2024	2/12/2024
Santa Clara	1/31/2023	1/31/2023	2/16/2023	2/1/2024	2/15/2024	2/22/2024
Santa Cruz	4/6/2023	4/14/2023				
Shasta	1/31/2023	2/2/2023	2/16/2023	1/30/2023	2/15/2024	2/21/2024

DHCS Status Chart of County RERs Received
August 22, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		4/2/2024
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023	5/21/2024	5/29/2024	6/10/2024
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	5/1/2024
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023	4/4/2024	4/5/2024	4/19/2024
Total	**57**	**42**	**57**	**55**	**51**	**53**

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Calendar (Tentative)

Focus areas are identified through the Commission's Strategic Plan goals and objectives. The 2024-2027 goals include: Champion Vision into Action, Catalyze Best Practice Networks, Inspire Innovation and Learning, and Relentlessly Drive Expectations.

The Commission's 2024-27 North Star priority is to accelerate system-level improvements to achieve early, effective, and universally available services. This priority will guide the evolution and design of the Commission's initiatives and projects, further informed by three more clearly defined operational priorities: (1) Build foundational knowledge, (2) Close the gap between what is being done and what can be done, and (3) Close the gap between what can be done and what must be done.

Meeting locations are considered based on agenda items, ease of access for Commissioners, and site visit considerations.

The draft calendar below reflects efforts to align the Commission meeting focus areas with priorities outlined in the 2024-2027 Strategic Plan. **All topics and locations subject to change**.

Dates	Locations	Focus Areas*
September 26	Los Angeles	Early Intervention Universal Screenings Draft Report Quarterly Strategic Plan Report Out 0-5 Mental Health Wellness
October 24	Sacramento	Chair and Vice Chair Election Impact of Firearm Violence Report Community Engagement Planning Innovation
November 21	Los Angeles	Commission Research Agenda Behavioral Health Transformation Progress Report Legislative Priorities for 2025 Quarterly Strategic Plan Report

*NOTE: The priorities listed are not the only agenda items under consideration for each month.