COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board

Public Forum Meeting: Monday, June 26, 2017, 6:00 PM – 7:00 PM
Regular Meeting: Monday, June 26, 2017, 7:00 PM – 9:00 PM
Committee Workshops: Monday, June 26, 2017

137 N. Cottonwood St., Woodland, CA 95695 – Thomson Conference Room, Bauer Building

All items on this agenda may be considered for action.

This meeting will begin with a public forum meeting at 6:00 PM – 7:00 PM , followed by the regular board meeting from 7:00 PM – 8:00 PM and Committee Meetings from 8:00 PM – 9:00 PM . This agenda reflects the regular meeting agenda items.

CALL TO ORDER ----------7:00 PM – 7:05 PM

1. Welcome and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes from May 22, 2017
5. Member Announcements
6. Correspondence

TIME SET AGENDA ----------7:05 PM – 7:15 PM

7. Crisis Intervention Training (CIT) Presentation: Mike Summers, CIT Training Coordinator

TIME SET AGENDA----------7:15 PM – 7:30 PM

8. MHSA INN Proposal Presentation: Resource Development Associates (RDA)

CONSENT AGENDA----------7:30 PM – 7:45 PM

9. Mental Health Director's Report – Karen Larsen

a. Personnel
b. Psychiatrist Staffing
c. MHSA Housing Project
d. MHSA 3 Year Plan
e. Public Guardian Transition
f. Proposition 47 Grant
g. Budget Update
h. Davis Site
i. Maddy Funds

REGULAR AGENDA----------7:45 PM – 7:55 PM

10. Board of Supervisors Report – Supervisor Don Saylor
11. Chair Report – James Glica-Hernandez

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

CONTINUED ON REVERSE

PLANNING AND ADJOURNMENT ---------- 7:55 PM – 8:00 PM

12. Future Meeting Planning and Adjournment – James Glica-Hernandez
    a. Long Range Planning Calendar Discussion and Review
    b. Next Meeting Date and Location – August 28, 2017 at 1212 Merkley Avenue, West Sacramento, CA 95691, AFT Library Community Room.

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, June 23, 2017.

Iulia Bodeanu, Administrative Services Analyst
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services Agency

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Local Mental Health Board
Meeting Minutes

Monday, May 22, 2017, 7:00 – 9:00 PM
1212 Merkley Ave, West Sacramento, CA 95691
AFT Library Community Meeting Room

Members Present: James Glica-Hernandez, Bret Bandley, Richard Bellows, Laurie Ferns, Martha Guerrero, Reed Walker, Ajay Singh, June Forbs, Robert "Bob" Schelen, Bret Bandley, Brad Anderson, Sally Mandujan, Niki King, Tom Waltz, Don Saylor

Members Excused: Juliet Crites

Staff Present: Karen Larsen, HHSA Director, Mental Health Director, and Alcohol and Drug Administrator
Laurie Hass, Deputy Public Guardian HHSA
LMHB Administrative Support
Iulia Bodeanu, HHSA Administrative Services Analyst, LMHB Administrative Support

CALL TO ORDER

1. **Welcome and Introductions:** The May 22, 2017 meeting of the Local Mental Health Board was called to order at 7:00 PM. Introductions were made.
2. **Public Comment**
   - No Public Comment
3. **Approval of Agenda**
   Motion: Nicki King to approve the agenda as amended **Second**: Martha Guerrero **Discussion**: To include mental health board training happening on June 10th in the member announcements. **Vote**: Unanimous to accept the agenda as amended.
4. **Approval of Minutes from the April 24, 2017 Meeting**

   Motion: June Forbes **Second**: Reed Walker **Discussion**: None **Vote:** Unanimous, 1 Abstention, Richard Bellows
5. **Member Announcements**
   - NAMI Annual Company Picnic held the first Wednesday in June in in Davis. (flyer)
   - June 10th Board Member Training from 10:00am to 3:00pm. A sign-up sheet for the training went around.
6. **Correspondence**
   - James Glica-Hernandez presented the LMHB Strategic Plan and Annual Update to the Board of Supervisors meeting on March 23, 2017.
   - The Board of Supervisors presented the LMHB with a resolution for mental health awareness month

TIME SET AGENDA

7. **Conservatorship Presentation and Discussion:** Laurie Hass, HHSA Deputy Public Guardian
8. **No CIT Presentation**

CONSENT AGENDA

9. **Mental Health Director's Report:** The following item(s) were pulled from Karen Larsen's Mental Health Director's Report for additional discussion.

   Item 9.a. State of Reform Conference

   - The objective of the State of Reform conference is a non-partisan annual conference that looks at health policy and health care and how it has been rolled out. The conference had presentations regarding healthcare implementation.

   Item 9.d. Housing Project

   - The ribbon cutting ceremony for new MHSA housing project will be on June 27, 2017.

   Item 9.h. Crisis Management Program

   - Mental Health urgent care has been widely discussed at the Local Mental Board and the Crisis Management Program is an opportunity to have those going through a mental health crisis go somewhere else other than a hospital or law enforcement involvement during a crisis. Clinical services would be available with private rooms for those that do not meet 5150 criteria. This will be a new access point for services.

REGULAR AGENDA

10. **Chair Report:** Chair James Glica-Hernandez led the group on the following topics.

    - Health Council Report: The Health Council is a gathering of community leaders, HHSA staff, providers and contractors that act as an advisory body for mental and physical health. Development of crisis management system was discussed.

    - Discussion regarding HHSA's and the County's support of the Affordable Care Act. Proposal to create an Ad Hoc Committee to write a letter to Yolo County legislators and Washington DC Legislators to advocate for sustaining the Affordable Care Act and relay concerns regarding the American Health Care Act. Board members James Glica-Hernandez, Ajay Singh, Martha Guerrero and Laurie Ferns. The Board of Supervisors will adopt a resolution in support of the Affordable Care Act at the 05/23/17 meeting.

    - Karen Larsen acknowledgement the board's involvement in the continuum of care workgroup and stepping up initiative as well as Tom Waltz involvement in the process. Thank you to everyone who has taken the lead at intercept one which is the initial law enforcement contact point.

11. **Annual Election of Officers:** All

    a. Appointments and Re-Appointments

       - **Motion**: Bob Schelen suggested that current officers should remain in their positions for another year **Second**: Bret Bandley **Discussion**: To have current Chair, James

Glica-Hernandez and Vice-Chair Nicki King remain in their positions.
Vote: Unanimous

- Sally Mandujan stated that she would step down as Secretary. **Motion**: June Forbes nominated Reed Walker as Secretary. **Second**: Nicki King seconded the nomination **Vote**: Unanimous. Thank you to Sally Mandujan for her service was expressed by James Glica-Hernandez.

12. LMHB Meeting Calendar Location Discussion: Richard Bellows

- There are ten meetings with three venues per year. There is a need for publicly available venues and having meetings in each of the three locations be equally represented for accessibility. At the moment the meetings are are not equally distributed among the three locations of West Sacramento, Woodland and Davis. A discussion was held and it was agreed to have one meeting in the rural area such as Winters or Esparto. An Ad Hoc Committee was created to find locations for future LMHB meetings. The Committee includes Richard Bellows, Reed Walker and James Glica-Hernandez.

13. Board of Supervisor's Report: Supervisor Don Saylor

- Affordable Care Act resolution is on the next Board of Supervisor's meeting agenda. Supervisor Saylor encouraged Local Mental Health Board members to email Board of Supervisors members to voice their opinions on the ACA regarding passing the resolution.

- It is budget season and the Board of Supervisors will be adopting a preliminary budget in June. In Home Support Services cost re-allocation will be implemented. The cost impact on the county will be less than was anticipated.

PLANNING AND ADJOURNMENT

14. Future Meeting Planning and Adjournment: James Glica-Hernandez

- James Glica-Hernandez encourage board members to submit their committee agenda items before the next board meeting, which will include committee meetings.

- Next Meeting Date and Location – June 26, 2017 at the Bauer Building, Thomson Conference Room, 137 N. Cottonwood Street, Woodland, CA 95695

- This meeting was adjourned at 9:06 PM.

Yolo County MHSA FY 2017-2020 Innovation Program Plan Description

Board and Care Study Project

Prepared by:

Resource Development Associates

April 13, 2017

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Executive Summary

During the Community Program Planning (CPP) process to develop the Yolo County Mental Health Service Act (MHSA) Three-Year Program and Expenditure Plan for 2017-2020, stakeholders identified a lack of housing options for people with the most intense service needs as a primary problem, specifically the extreme shortage of Board and Care facilities. Without adequate Board and Care facilities within the County, Yolo County residents who require that support to live in the community are placed in out-of-county facilities. This creates a variety of challenges, including:

- Consumers are farther away from their families, other natural supports, and health and mental health services, which creates barriers to their recovery.
- Consumers with the highest level of need are less likely to be accepted to a Board and Care placement when there are consumers with less intense need also competing for available beds.
- County staff have to travel further distances to meet with consumers, which makes it more difficult to monitor quality as well as provide support to consumers and Board and Care staff.
- Medi-Cal and other benefits connected to a person's county of residence may be switched, creating unnecessary challenges for the consumer as well as administrative burdens to staff.

The County and stakeholders further discussed the problem with the intention of discovering potential solutions, and in the process, realized that 1) this was a complex problem that required further research to understand the intersecting factors that contribute to the Board and Care shortage, and that 2) addressing this shortage would require creative solutions informed by an accurate understanding of the factors that contribute to the problem. The County, in partnership with stakeholders, developed this INN project as a participatory study towards a more thorough and accurate understanding of the problem, and as a vehicle for working together to develop creative solutions.

The Board and Care Study Project seeks to explore and address the issues identified by Yolo County stakeholders around access to Board and Care services, and to achieve the following learning goals: 1) increase understanding of the dynamics underlying the Board and Care bed shortage, 2) identify strategies and incentives to increase Board and Care bed capacity, 3) identify capacity building approaches to incentivize the placement of consumers with the most intense service needs in available Board and Care beds, 4) and develop an implementation plan to increase access to Board and Care placement for those with the most intense service needs. Through this project, the Yolo County Health and Human Services Agency (HHSA) plans to gather qualitative data from consumers, their families, Board and Care operators, Community Care Licensing, and mental health providers; conduct a quantitative analysis of people currently placed or at risk of placement in out-of-county facilities; and conduct benchmarking interviews with other jurisdictions to identify potential strategies. HHSA then plans to engage stakeholders in using the data gathered to develop creative and actionable strategies to increase County Board and Care capacity. Following this study project, HHSA plans to implement the strategies developed to increase Board and Care capacity within the County.

County:	Yolo County
Project Name:	Board and Care Study
Date Submitted:	April 13, 2017

Project Overview

Primary Problem

Background

While Yolo is considered a mid-sized county with a population of approximately 213,000, the County spans a significant geographic area of over 1,000 square miles.[1] The County—with its distinct geographic, cultural, and socio-economic characteristics—has the unique challenge of providing services to diverse groups and communities that are also geographically varied, and must contend with the need for flexible service delivery, cultural competency across groups, transportation, and access to services across a vast territory.

High levels of poverty (over 17% of the population lives below the poverty line[2]) and rural and cultural isolation affect many residents of the County. In addition, one in six residents was uninsured and one in four experienced severe housing problems in 2016.[3] The demographics of behavioral health consumers and those in need of behavioral health services mirror those of the County's population. Furthermore, the rate of hospitalizations for mental health diagnoses in Yolo County has been increasing since 2008, particularly for hospitalizations for psychoses.[4] During the County's MHSA CPP process, stakeholders connected the challenge of meeting the behavioral health needs of the County's diverse and scattered population to multiple factors, including the need for increased coordination across providers, narrow transportation options, limited specialized crisis service hours, and the need for expanded consumer access to health and wellness service coordination.

Yolo County has employed considerable efforts to strengthen its crisis services and reduce psychiatric hospitalizations, incarcerations, and homelessness. The County provides multiple services for adults with serious mental illness (SMI), including the following: 1) community-based navigation centers that include both recovery-based mental health and social services; 2) intermittent field-based case management services (to maintain linkage to psychiatric care and community resources); 3) assessment and plan development; 4) (brief) psychotherapy, targeted case management, and rehabilitation; 6) crisis intervention; and 7) collateral contacts . Yolo County also offers programs to link adults to temporary or permanent homes, substance use treatment and support, and crisis intervention. In addition, Yolo County

[1] US Census Bureau, 2015, http://www.census.gov/quickfacts/table/PST045215/06113
[2] US Census Bureau, 2015, http://www.census.gov/quickfacts/table/PST045215/06113
[3] http://www.countyhealthrankings.org/app/california/2016/rankings/yolo/county/outcomes/overall/snapshot
[4] Yolo County Health Department. (2014). Community Health Status Assessment. Accessed on March 24, 2017 from http://www.yolocounty.org/Home/ShowDocument?id=25983.

offers Full Service Partnership (FSP) for adults with severe and persistent mental health conditions, substance use disorders, chronic homelessness, and/or forensic or behavioral health involvement. These efforts reflect the deep commitment of Yolo County HHSA leadership, staff, providers, consumers, family members, and other stakeholders to the meaningful participation of the community as a whole in designing mental health programs that are wellness and recovery focused, client and family driven, culturally competent, integrated, and collaborative.

Adults with severe mental illness require comprehensive wrap-around supportive services, including housing. However, Yolo County is experiencing a general housing shortage, and options for housing and independent living are severely limited. In addition, none of the aforementioned mental health or housing support programs offer adults with severe mental illness a supervised environment—such as a Board and Care home—where they can receive 24/7 support. Without a stable and safe housing environment, it would be unlikely that Yolo County could maintain the necessary continuum of care for adults with severe mental illness.

Board and Care homes play a critical role in the mental health system by providing a safe and dignified housing option to support individuals with SMI to live in the community, as well as an environment for the provision of behavioral health services and resources. Board and Care homes— licensed by the California Department of Social Services Community Care Licensing division as adult residential facilities—are non-nursing assisted living facilities that provide much-needed services to adults 18-59 years of age. Board and Care homes vary from small to large facilities, and provide housekeeping services, social and recreational activities, meals and meal supervision, assistance with activities of daily living (e.g., bathing, dressing, eating), and independent adult living services (e.g., budgeting, transportation, communication). Facilities also offer assistance with going to medical appointments, and provide updates on consumer status to mental health providers. In addition, Board and Care homes are able to store and monitor self-administration of medication on an appropriate schedule, which is critically important for individuals with SMI. Furthermore, Board and Care homes house individuals at risk of being placed in a skilled nursing facility or other institutional environment, thereby resulting in cost savings to the community.[5] However, while Board and Care homes can provide a safe setting for persons with SMI, quality of care and environment vary greatly among facilities.

Problem Statement

During both the 2016-2017 MHSA Annual Update and 2017-2020 Three-Year Plan CPP processes, HHSA leadership and community stakeholders identified three interwoven factors that present major challenges to providing an appropriate level of housing assistance and support for adult consumers with the most intense service needs (Figure 1).

[5] Doty, P. (2000). *Cost-Effectiveness of Home and Community-Based Long-Term Care Services*. USHHS/ASPE Office of Disability, Aging and Long Term Care Policy. U.S. Department of Health and Human Services.

Figure 1. Outline of major challenges identified by HHSA leadership and community stakeholders

- There **are not enough** Board and Care Facilities in Yolo County.
- Due to the limited amount of Board and Care Facilities, Board and Care Facilities are **less likely** to **accept clients** with **more intensive needs**.
- Mental health consumers with the **highest needs** are placed **out of county** and away from their homes and families and/or support system.

Community stakeholders expressed concerns about extremely limited residential and step-down options for adults, which may contribute to longer hospital stays and out-of-county placements. In addition, Board and Care facility shortages disproportionately impact those with the highest level of need.

Insufficient Board and Care Facilities

In Yolo County, there are only eight adult residential facilities to serve Yolo County residents (Table 1), some of which are targeted to people with developmental disabilities. The current available Board and Care bed space is not sufficient to meet the high need for persons with SMI. Historically, many Yolo County Board and Care facilities have closed down, while only a few of those remaining provide bed space for adults with SMI.

Table 1. Board and Care Homes in Yolo County[6]

Facility	Population Served	Capacity	Years in Operation
Pine Tree Gardens West	Individuals with SMI	15	7
Pine Tree Gardens East	Individuals with SMI	13	7
Davis Summer House	Individuals with Developmental Disabilities	14	24
Summer House Inc.	Individuals with Developmental Disabilities	12	42
E & J Griffin Family Care Home	Individuals with Developmental Disabilities	6	20
E & J Griffin Family Care Home II	Individuals with Developmental Disabilities	6	12
Tropical Villa-ARF	Individuals with Developmental Disabilities	6	12
V & P Truong Care Home, LLC	Individuals with Developmental Disabilities	4	6
Total and Range		76	6 – 42

[6] California Department of Social Services. Licensed Facility Search. Accessed on March 21, 2017 from https://secure.dss.ca.gov/CareFacilitySearch/.

Currently, individuals with SMI from Yolo County and two other nearby counties are living in out-of-county Board and Care facilities in Sacramento County; this leads to an exacerbation of the statewide shortage of Board and Care bed space.

Board and Care Facilities Less Likely to Accept Clients with Highest Needs

As bed capacity is limited, competition for Board and Care beds makes facilities more likely to accept consumers who are relatively easier to serve, require less support to adapt to a group living situation, and follow Board and Care facility rules with minimal difficulty. Currently, there are no incentives for Board and Care facilities in Yolo County to take on mental health consumers with higher service needs. Facilities are generally reticent to house consumers with mental health challenges, since staff may not have the mental health knowledge or capacity to support consumers' needs.

Adults with SMI who are unable to secure housing in a local Board and Care facility end up living in a Board and Care home outside of the County, with aging parents or other family members, in other arrangements that don't provide needed support (e.g., room and board), or on the streets. As the population in Yolo County continues to age, there is an additional threat that the large number of adults with SMI may no longer be able to live with their aging parents or family. This may further exacerbate the issue and have significant impact on the community and adult mental health system.

Clients with Highest Needs are Placed Out of County

HHSA realized that Board and Care bed shortages led to the clients with the highest needs being placed out-of-county and away from their homes, communities, and loved ones. Out-of-county placement directly interferes with continuity of care and is detrimental to consumers' recovery due to separation from their communities and local support systems. The Board and Care home setting, in conjunction with establishment of community ties, is considered a step towards independent living. Consumers' progress towards independent living is interrupted by out-of-county placement.

In addition, Yolo County mental health staff face barriers in providing services to clients due to the added distance of out-of-county placement. The resulting lack of Yolo County mental health staff available in out-of-county Board and Care facilities leads to decreased oversight and may result in more variation in quality of food, maintenance, and cleanliness. Furthermore, consumers may be placed in out-of-county Board and Care beds that were previously vacant because they were less desirable due to quality issues.

Providers also described the barriers they face in serving clients placed out of county, along with their overall concern for the wellness and recovery of consumers who may become isolated from their families and other support systems. Distance may also interfere with Board and Care staff assisting consumers to get to medical appointments. There are also difficulties that arise with changes in Medi-Cal assignment resulting from out-of-county placement.

Due to the detrimental effects of Board and Care bed shortages for adults with SMI, Yolo County is seeking to develop an innovative approach to expand the bed capacity of local Board and Care homes for adults with SMI, and to incentivize them accepting clients with the highest level of need.

Need Statement

Evidence supports the significant need and effectiveness of building Board and Care bed capacity for adults with serious mental illness (SMI). In a Los Angeles study, results indicated that seriously mentally ill residents' quality of life may be enhanced by improving the social climate, increasing the number of beds in the home, and placing the home in a neighborhood where the person may feel comfortable.[7] In addition, an Ohio study demonstrated that social and environmental features have a more significant impact on residents' psychological well-being, as compared to the physical features of a Board and Care home.[8] Additionally, Board and Care smaller group settings can foster social connections and support.

Shortages in Board and Care homes have led to adults with SMI living in Board and Care facilities outside of the County, with aging parents or other family members, in other arrangements that don't provide needed support (e.g., room and board), or on the streets. HHSA firmly believes that mental health consumers with the highest needs should receive mental health treatment in their communities and close to their families, friends, and support networks. As a result, HHSA and stakeholders have identified the need to develop innovative strategies to build bed capacity as well as engage, incentivize, and support Board and Care facilities to serve consumers with more intense support needs. Furthermore, Yolo County requires an improved understanding of the factors contributing to Board and Care bed shortages in order to develop long-term strategies to address the problem.

Review of Relevant Literature and Practices

Literature Review

RDA reviewed relevant literature and existing practices to determine what has been done elsewhere to address this problem.

Methods

RDA performed a literature review of the current body of knowledge regarding innovative strategies to increase Board and Care bed capacity. Since literature was very limited for Board and Care homes that serve individuals with serious mental illness (SMI), RDA also reviewed literature related to strategies to improve Board and Care quality and capacity, barriers and challenges to expanding capacity for long-term residential care facilities, and barriers in access to Board and Care homes among persons with SMI.

Findings

[7] Mares, A.S., Young, A.S., McGuire, J.F., Resenheck, R.A. (2002). *Residential Environment and Quality of Life Among Seriously Mentally Ill Residents of Board and Care Homes*. Community Mental Health Journal. 38(6): 447-458.

[8] Nazami, K.H., Eckert, J.K., Kahana, E.., Lyon, S.M. (1989). *Psychological Well-Being of Elderly Board and Care Home Residents*. Gerontologist. 29(4): 511-516.

Literature related to Board and Care facilities for individuals with SMI primarily focused on assessing facility setting and resident outcomes, rather than strategies to expand bed capacity.[9] There is very limited literature regarding innovative strategies to build Board and Care bed capacity for adults with SMI, but what literature there is suggests factors that may exacerbate problems with Board and Care shortages. For example, in California agencies in the mental health industry report that many adult residential facilities have closed due to lack of funding or increased regulatory requirements.[10]

Board and Care facilities face challenges in financial sustainability due to regulatory penalties and rising costs of living.

A national survey of residential care facilities identified the following two major challenges for expansion of services and capacity: 1) payments were incomplete (e.g., housing, food, and utilities not covered; Supplemental Security Income (SSI) check insufficient to fill gap), and 2) there is a general shift to managed care.[11]

The increasing challenges of financial sustainability pose an even greater burden on the smaller Board and Care homes. A study across seven states found that smaller nonprofit homes were more likely to engage in productive activities (e.g., more kinds of activities within the facility, more excursions into the community) compared to larger for-profit homes, particularly for persons with greater impairment in social functioning.[12] However, although smaller operations may yield better results, they face significant challenges in remaining financially stable and sustainable. Larger operations, such as those managed by chain providers, have access to financial resources and electronic health records which can help to overcome sustainability barriers and increase bed capacity.[13,14] Yolo County will need to address the financial barriers faced by Board and Care homes when expanding bed capacity for adults with serious mental illness. However, this issue is unlikely to be solved solely by addressing funding issues.

In California, adult residential facilities are prohibited from accepting or retaining individuals whose primary need is acute psychiatric care due to a mental disorder; furthermore, adult residential facilities are permitted to evict residents who pose a threat to their mental or physical health or the safety of

[9] Wunderlich, G.S., and Kohler, P.O. (2001). *Improving the Quality of Long-Term Care*. Institute of Medicine Committee on Improving Quality in Long-Term Care. National Academic Press. Washington, D.C.
[10] Sult, T., and Partners, C. (2013). *The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities*. California HealthCare Foundation. Accessed on March 20, 2017 from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20R/PDF%20RightPlaceSupportiveHousing.pdf.
[11] Caffrey, C., Harris-Kojetin, L., and Sengupta, M. (2015). *Variation in Operating Characteristics of Residential Care Communities, by Size of Community: United States, 2014*. Centers for Disease Control and Prevention National Center for Health Statistics. NCHS Data Brief. 222.
[12] Nagy, M.P., Fisher, G.A., and Tessler, R.C. (1988). *Effects of Facility Characteristics on the Social Adjustment of Mentally Ill Residents of Board-and-Care Homes*. Psychiatric Services. 39(12): 1281-1286.
[13] Chain affiliation is defined as ownership by a person, group, or organization owning or managing two or more residential care communities, including corporate chains.
[14] Caffrey, C., Harris-Kojetin, L., and Sengupta, M. (2015). *Variation in Operating Characteristics of Residential Care Communities, by Size of Community: United States, 2014*. Centers for Disease Control and Prevention National Center for Health Statistics. NCHS Data Brief. 222.

themselves or others.[15] This regulation is intended to prevent Board and Care homes from becoming substitutes for mental health treatment centers. However, it is not meant to be a disincentive for Board and Care homes serving adults with non-acute SMI. Rather, Board and Care homes are encouraged to have staff who are knowledgeable about connecting residents to mental health and behavioral health services. In practice, Board and Care homes may be deterred from accepting adults with SMI because of potential fines and citations resulting from disorderly or harmful behavior. As regulatory changes continue to impact Board and Care homes, Yolo County will need to take into consideration the underlying complex dynamics and challenges Board and Care homes face when planning bed capacity expansion for adults with SMI.

Studies have revealed disparities in access and quality of care among residents of long-term care facilities. A study across four states revealed racial disparities in relation to long-term care experiences; African Americans tended to be concentrated in a few predominantly African American facilities, while the vast majority of Whites resided in predominantly White facilities. Furthermore, African Americans tended to be located in rural African American communities, and to have lower ratings of cleanliness/maintenance and lighting.[16] Further evidence is needed to determine if the root causes of disparities are economic factors, exclusionary practices, or other factors. Impact of disparities should be taken into consideration when expanding bed capacity in Board and Care homes for adults with SMI.

Review of Existing Practices

Methods

RDA performed a literature review of best practices, recommendations, and case studies of Board and Care innovative strategies used within and outside of California. Current strategies related to Board and Care facilities for individuals with serious mental illness (SMI) primarily focused on changing facility setting and activity options, rather than expanding bed capacity.[17] There is very limited availability of case studies regarding innovative strategies to build Board and Care bed capacity for adults with SMI.

Findings

There is limited availability of publications describing best practices or case studies of innovative strategies to build Board and Care bed capacity. Furthermore, given the variations of Board and Care homes across states (e.g., quality of home, type of home, size, location, physical environment, quality of care, staff), it

[15] Sult, T., and Partners, C. (2013). *The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities*. California HealthCare Foundation. Accessed on March 20, 2017 from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20R/PDF%20RightPlaceSupportiveHousing.pdf.

[16] Howard, D.K., Sloane, P.D., Zimmerman, S., Eckert, K., Walsh, J.F., Buie, V.C., Taylor, P.J., Koch, G.G. (2002). *Distribution of African Americans in Residential Care/Assisted Living and Nursing Homes: More Evidence of Racial Disparity?*. American Journal of Public Health. 92(8): 1272-1277.

[17] Wunderlich, G.S., and Kohler, P.O. (2001). *Improving the Quality of Long-Term Care*. Institute of Medicine Committee on Improving Quality in Long-Term Care. National Academic Press. Washington, D.C.

can be difficult to draw confident conclusions from comparisons across similarly labeled facilities.[18] In the review of practices, RDA did not identify any counties in California who are employing an innovative strategy to build bed capacity in Board and Care homes for individuals with SMI.

Most counties in California are experiencing a shortage of Board and Care homes, and the most common approach is increased funding support such as patch payments. However, this approach has not addressed issues with capacity and problems in access to Board and Care homes for individuals with SMI. Based on RDA's review of existing strategies, there are very few counties in California implementing innovative strategies to support Board and Care homes for adults with SMI. There are no counties using MHSA Innovation funds to build bed capacity. Some counties, including Riverside, used MHSA Innovation funds to retain Board and Care homes and prevent loss of bed capacity in their jurisdiction. San Joaquin County previously used MHSA Innovation funds to implement Residential Learning Communities, which aimed to increase service quality and improve outcomes for high-frequency users of unplanned mental health services (e.g., admission to psychiatric health facilities, emergency response by law enforcement) among individuals housed in Board and Care facilities.[19]

Other states have implemented various strategies to prioritize specific target populations or target facilities to expand capacity of long-term residential care facilities:

- In Maine, policy makers have recently proposed expansions of intense residential treatment services by increasing the number of beds, particularly for children and adolescents living with serious emotional disturbance and co-occurring conditions. However, they acknowledge the following challenges they will need to address before expanding bed capacity: existing bed capacity limits, mental health workforce shortages, insufficient staffing, and funding (e.g., lack of coverage by some private commercial health plans).[20]
- The state of Arkansas prioritized expansion of bed capacity for residential care facilities with high occupancy and for residential care facilities replacing older facilities, and did not expand bed capacity for facilities with violations in the last year.[21]
- A North Dakota study explored the potential implementation of the following approaches for expanding the availability of and access to community-based residential care facilities: changes in regulation; changes in licensure requirements; development or expansion of a mental health waiver program for the seriously mentally ill; modifications to the Medicaid Rehab Option; re-evaluation of eligibility policies; evaluation of best practices; and improvements or expansions in compliance and review programs. In addition, the study found that assisted living facilities

[18] Harris-Kohetin, L., Sengupta, M., Park-Lee, E., and Valverde, R. (2013). *Long-term care services in the United States: 2013 overview*. National Center for Health Statistics. Vital Health Statistics 3(37).
[19] San Joaquin County Behavioral Health Services. (2011). Mental Health Services Act Innovation Component: Three-Year Program & Expenditure Plan. Accessed on March 24, 2017 from http://sjmhsa.net/Documents/FINAL%20Innovation%20Plan%205-11-11.pdf.
[20] Governor's Task Force on Mental Health. (2016). Immediate Improvements in Inpatient Bed Capacity and Level of Care Transitions: Proposed Solutions (Draft).
[21] HSC Regulation 200M Residential Care Facility (RCF) Methodology (10/05). Accessed on March 20, 2017 from http://www.sos.arkansas.gov/rulesRegs/Arkansas%20Register/2005/oct_2005/049.00.05-004F-7931.pdf.

primarily serve individuals who are able to pay with private funds, which excluded people who are funded through Medicaid or SPED program. Thus, the state was recommended to expand the availability and utilization of assisted living services by individuals who are Medicaid and SPED-eligible.[22]

- In Massachusetts, there are limited Medicaid openings available in licensed assisted living residences. Thus, plans frequently use alternative approaches such as bringing services into subsidized housing through the state's Group Adult Foster Care Program. [23]

The problems related to Board and Care facility shortage are complex and cannot be solved by any one strategy alone. Board and Care facility shortages are influenced by multiple interdependent factors, and strategies that only address one factor would be unlikely to succeed. Successful strategies for expanding bed capacity in Board and Care facilities will require a systems-based approach that considers multiple interdependent factors contributing to shortages, including secure funding sources, financial sustainability, quality of care, regulations, residents' access to resources, culturally competent care, neighborhood acceptance (i.e. NIMBY-ism), and ensuring support systems are in place to support residents with the greatest needs.

By implementing the Board and Care Study Project, Yolo County will be able to explore the multiple factors that influence Board and Care facility shortages in Yolo County to inform the development of a plan to increase access for Yolo County residents. Ultimately, the learning from this project may contribute to widespread practice or policy changes, as these findings can inform similar counties experiencing the same challenges.

Proposed Project

Innovative Component

Evidence to inform successful strategies for expanding Board and Care bed capacity is very limited, and evidence regarding innovative strategies is even more limited. [24] Furthermore, Yolo County has historically addressed the problem using patch funding, but this approach has only yielded short term results, and shortages continue to persist. Thus, Yolo County and MHSA stakeholders identified the need to develop a better understanding of the factors influencing Board and Care shortages, which will inform evidence-based and long-term strategies that address underlying factors contributing to the shortages.

The Board and Care Study Project (BCSP) meets the criteria of an Innovation project by utilizing a participatory research approach to understand and develop strategies to address the challenges around

[22] Myers and Staugger LC. (2014). North Dakota Long Term Care Study Deliverable 3. Accessed on March 20, 2017 from https://www.nd.gov/dhs/info/pubs/docs/medicaid/ltc-interim-report-final.pdf.
[23] Sult, T., and Partners, C. (2013). *The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities*. California HealthCare Foundation. Accessed on March 20, 2017 from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20R/PDF%20RightPlaceSupportiveHousing.pdf.
[24] Wunderlich, G.S., and Kohler, P.O. (2001). *Improving the Quality of Long-Term Care*. Institute of Medicine Committee on Improving Quality in Long-Term Care. National Academic Press. Washington, D.C.

Board and Care services in Yolo County with new programs and services. The process of implementing the Board and Care Study Project will involve data gathering and analysis followed by implementation of programs and services in response to the data.

The BCSP will implement an approach that is new to the overall mental health system, which is one of the three approaches specified in CCR, Title 9, Sect. 3910(a). Using a novel data-driven approach for solving Board and Care bed capacity, Yolo County will develop the evidence base regarding major factors influencing Board and Care bed shortages for adults with serious mental illness (SMI). A growing body of evidence in the social and behavioral sciences has demonstrated the effectiveness of developing program strategies using an evidence-based approach, which integrates the best available evidence from data, research, and evaluation.[25] Yolo County plans to use an evidence-based decision-making process to develop thoughtful and comprehensive strategies to address barriers in access to and availability of Board and Care beds.

The challenges around Board and Care facilities discussed above are not unique to Yolo County. Although other counties in California have experienced similar issues, particularly in mid-sized counties, no other counties in California have employed rigorous data-informed strategic planning. Findings from the Board and Care Study Project can inform best practices in Yolo County as well as similar counties facing the same challenges. This project will provide a model for a data-driven approach to addressing barriers in access and availability of Board and Care bed space, particularly for adults with serious mental illness. In addition, the evaluation will assess the impact and importance of the Board and Care Study Project, which contributes to new knowledge from which further data-driven innovations can emerge. Ultimately, the learning from this project may contribute to widespread practice or policy changes.

Goals and Objectives

The Yolo County MHSA Innovation Board and Care Study Project (BCSP) aims to **improve the quality of services and outcomes** and **increase access to services** for mental health consumers with intensive needs by developing Board and Care capacity building strategies, while **promoting interagency and community collaboration**. The BCSP aims to develop an understanding of the Board and Care shortage problem and utilize data to inform an actionable plan that achieves the following goals:

- Incentivize current in-county Board and Care facilities to build more beds and accept consumers who may be perceived as "difficult to serve", including financial and non-monetary mechanisms;
- Provide support to Board and Care facilities to work with consumers with more intense service needs; and
- Build staff and provider capacity to serve consumers with higher needs.

The BCSP seeks to explore and address the issues identified by Yolo County stakeholders around access to Board and Care services. The objectives of the study are to accomplish the following:

[25] McColskey, W., and Lewis, K. (2007). *Making Informed Decisions About Programs, Policies, Practices, Strategies, & Interventions.* SERVE Center. Accessed on March 29, 2017 from http://www.serve.org/uploads/files/Making%20Informed%20Decisions.pdf.

- Gather and analyze data to investigate how to alleviate the major factors impacting Board and Care availability and services in Yolo County; and
- Identify approaches and strategies based on the outcome of the data gathering.

The BCSP seeks to explore and gain knowledge around the following key learning goals:

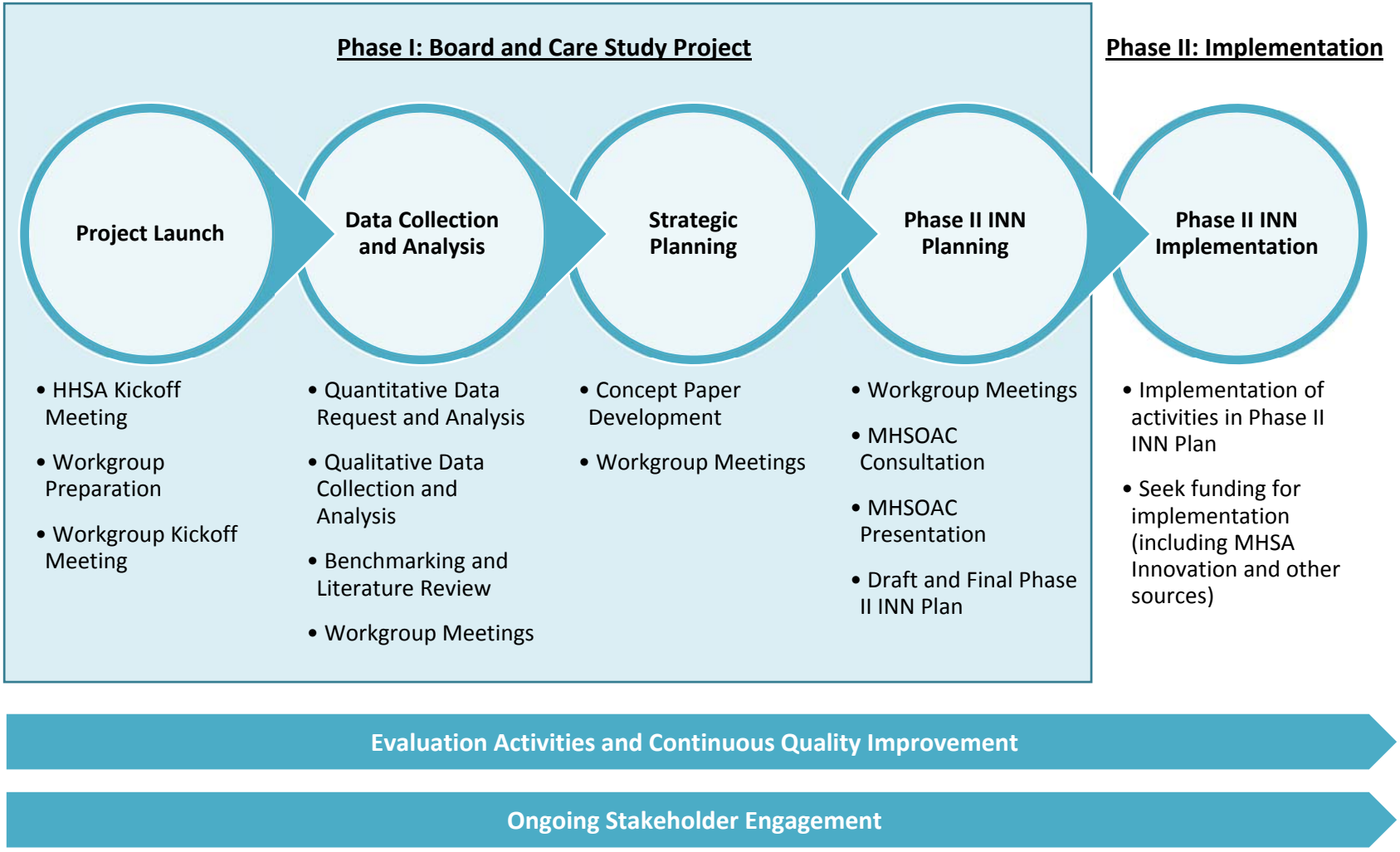
- Increased understanding of the dynamics underlying the Board and Care bed shortage;
- Identification of strategies and incentives to increase the Board and Care bed capacity;
- Identification of capacity building approaches to incentivize the placement of consumers with the most intense service needs in available Board and Care beds; and
- An evidence-based implementation plan to increase access to Board and Care placement for those with the most intense service needs.

By implementing the BCSP, Yolo County will be able to improve understanding of the multiple factors influencing access and availability of Board and Care facilities in Yolo County.

Overview of Strategic Approach

The Board and Care Study Project (BCSP), which constitutes the first phase of a long-term strategy envisioned by Yolo County, will be followed by a separate project focused on the implementation of strategies identified in the BCSP. **Phase I: Board and Care Study Project** will investigate factors influencing availability and access to Board and Care services in Yolo County, and utilize findings to inform the development of Phase II Innovation (INN) Planning. During **Phase II: Implementation**, Yolo County will seek additional funding sources to support implementation activities, including MHSA INN funds, if applicable. In order to contextualize the BCSP within the scope of the long-term vision, plans for both Phase I (i.e., Board and Care Study Project) and Phase II (i.e., Implementation) will be described in this document. Figure 2 summarizes the activities and processes planned for addressing Board and Care facility shortages in Yolo County.

Figure 2. Yolo County Board and Care Study Project and Long Term Strategy



Board and Care Study (Phase I) Activities

Findings from Phase I: Board and Care Study Project will inform strategies to expand bed capacity in Board and Care facilities for adults with serious mental illness (SMI), particularly for Yolo County residents placed in out-of-county Board and Care facilities.

The BCSP will gather and analyze data to investigate how to alleviate the major factors influencing Board and Care availability and services in Yolo County, with the goal of creating programs and implementing strategies based on the outcome of the data gathering. As illustrated in Figure 2, the project will have four stages with the following distinct activities:

1) Project Launch,
2) Data Collection and Analysis,
3) Program Development, and
4) Phase II INN Planning.

Yolo County will coordinate with the MHSA system of care to promote interagency collaboration. In addition, Yolo County will communicate and engage with consumers, consumers' family members and friends, and Board and Care facility operators to promote community collaboration. The project will implement a set of community meetings and information-gathering activities to engage stakeholders in all stages of the planning and strategy development process, in order to ensure that the MHSA Innovation project reflects stakeholders' experiences and suggestions. Stakeholder engagement, evaluation activities, and continuous quality improvement will be ongoing throughout the Board and Care Study Project.

Project Launch. The initial activities of the project will aim to build a foundation of partnership and community engagement. HHSA will conduct a kickoff meeting to introduce the project to partners and stakeholders. The purpose of the kickoff meeting is to provide information about the proposed planning process and timeline, and to gather feedback to improve the proposed process. A workgroup will be formed from planners and stakeholders to support implementation and strategic planning. HHSA will then conduct the workgroup preparation and kickoff meeting to provide training and technical assistance to the workgroup. Activities of the Project Launch phase will help to ensure that the process is reaching important stakeholders while garnering community buy-in for the process.

Data Collection and Analysis. Through a Community Program Planning (CPP) process, HHSA will conduct a quantitative and qualitative needs assessment with stakeholders utilizing evidence-based techniques proven to yield strong, accurate data. The goal of this phase is to:

- Explore the underlying dynamics that contribute to the identified needs;
- Deepen our understanding of the challenges that Board and Care facility operators experience when serving consumers with a high degree of need; and
- Investigate what strategies may be most helpful in serving the identified population.

The following CPP activities will be conducted to collect quantitative and qualitative data that informs the next phase of program development:

- Focus groups and interviews with consumers, Board and Care facilities, providers, and other key stakeholders, including Community Care Licensing;
- Data analysis and profile of Yolo residents receiving out-of-county treatment or at risk of being placed out of county; and
- Best practice and/or benchmarking research regarding Board and Care facilities.

These activities will result in INN programs and strategies that are informed by Board and Care facility providers, consumers receiving the services, and MHSA stakeholders who participate in the CPP process. The workgroup will continue to convene to support strategic planning.

Program Development. During the Program Development phase, a concept paper will be developed which outlines an approach to building Board and Care bed capacity for adults with higher needs, drawing from data gathered in the Data Collection and Analysis phase of the project. Based on initial data gathered during the Innovation Plan CPP process, below are some specific approaches being considered:

- Provide Board and Care facility staff with training and technical assistance on working with consumers with more intensive needs;
- Employ Yolo's mobile Crisis Intervention Program (CIP) to support Board and Care staff;
- Arrange financial incentives for Board and Care facilities to serve adult consumers with high needs; and
- Develop financial models and increase support to open new facilities.

Through these or similar approaches, HHSA plans to build the county's Board and Care facilities capacity to serve Yolo County adult residents experiencing severe mental health issues. The workgroup will continue to convene to support strategic planning.

Phase II INN Planning. The final phase of the BCSP involves strategic planning for the program designed in the Program Development phase. The plans for implementation will be detailed in the Phase II Plan. The final plan will be developed in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), if the strategies meet INN funding requirements. If other available funds are more appropriate to fund the identified strategies, INN funds will not be requested for Phase II of this project. In addition, Yolo County will coordinate with the MHSA system of care to promote interagency collaboration and establish a foundation for successful implementation. In addition, Yolo County will communicate and engage with consumers, consumers' family members and friends, and Board and Care facility operators to promote community collaboration. The workgroup will continue to meet in support of strategic planning and implementation activities.

Following successful completion of the Board and Care Study Project, Yolo County will continue into Phase II: Implementation to implement the strategies outlined in the Phase II INN Plan.

The goal of MHSA INN programs is to provide mental health systems with an opportunity to learn from innovative approaches that will support system change and improve consumer outcomes. Through capacity building approaches created in partnership with community stakeholders, Yolo County HHSA's 2017-2020 MHSA INN program plans to address improving the quality of services and outcomes and increasing access to services specifically for consumers placed in out-of-county Board and Care facilities.

Evaluation Plan

Throughout the Board and Care Study Project (BCSP), the evaluators will concurrently conduct an evaluation process. The BCSP evaluation will address the following key learning questions:

- Does the BCSP lead to increased understanding of the dynamics underlying the Board and Care shortage?
- Does the BCSP lead to identification of strategies and incentives to increase Board and Care bed capacity?
- Does the BCSP lead to identification of capacity-building approaches to incentivize the placement of consumers with the most intense service needs in available Board and Care beds?
- Does the BCSP lead to the development of an evidence-based implementation plan to increase access to Board and Care placement for those with the most intense service needs?

After completion of the BCSP, the evaluators will conduct an evaluation of Phase II: Implementation to address the following key learning questions:

- Does the BCSP lead to increased Board and Care bed availability in Yolo County?
- Does the BCSP lead to increased placement of high-need consumers in Yolo County Board and Care facilities?
- Does the BCSP lead to increased access to support systems and providers inside Yolo County for Board and Care residents?

Planning and implementation of the evaluation will be informed by a continuous quality improvement process, including incorporation of feedback from providers, consumers, and consumers' loved ones. Evaluation activities will be grounded in MHSA values by ensuring data collection tools and stakeholder engagement activities are conducted in a culturally appropriate manner. Stakeholders will be asked to provide feedback on their experiences, and modifications to the process will be made as necessary to respond to the expressed needs. Stakeholders may include individuals from a wide variety of affiliations, including homeless, LGBTQ, transitional age youth, youth, older adults, consumers, consumers' family members, peer support workers, county staff, Latino, and mental health providers. Stakeholders will be recruited using a similar outreach approach employed in the MHSA CPP process.

As shown in Table 2, the BSCP will be evaluated on concretized process and outcome measures. Evaluators will work to identify data points and evaluation methods to measure program implementation and impact. Process indicators measure to what extent the program was implemented as intended, while outcome measures will provide information on the impact of the program on participants, community, and the mental health system overall.

The following table outlines the data to be collected and potential data sources listed by their respective key learning question (Table 2).

Table 2. Board and Care Project Evaluation Questions and Outcomes

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
Phase I: Board and Care Study Project			
Is there an increased understanding of the dynamics underlying the Board and Care bed shortage in Yolo County?	❖ Identified factors contributing to shortages	❖ ↑ Understanding of factors contributing to shortages	❖ Focus groups ❖ HHSA data
Did BCSP identify strategies and incentives to increase the Board and Care bed capacity?	❖ Identified strategies and incentives	❖ ↑ Knowledge of potential solutions for shortages	❖ Focus groups ❖ Literature review ❖ Benchmarking
Did BCSP identify capacity-building approaches to incentivize placement of consumers with the most intense service needs in available Board and Care beds?	❖ Identify capacity building approaches to incentivize in-county placement	❖ ↑ Knowledge of potential solutions for shortages	❖ Focus groups ❖ Literature review ❖ Benchmarking
Did the BCSP result in an implementation plan to increase access to Board and Care placement?	❖ Concept paper outlining evidence-based strategies	❖ Phase II INN Plan with evidence-based strategies	❖ Workgroup meetings
Phase II: Implementation			
Does the BCSP lead to increased Board and Care bed availability in Yolo County?	❖ # of Board and Care licensing applications ❖ Time between Board and Care license application and approval ❖ # Board and Care licensed	❖ ↑ # of Board and Care beds available ❖ Perceptions of Board and Care availability	❖ HHSA data ❖ Housing referral data ❖ State licensing data
Does the BCSP lead to increased placement of high-need consumers inside Yolo County Board and Care facilities?	❖ # of placed high-need consumers in Yolo County Board and Care facilities ❖ Amount of time high-need Board and Care residents remain placed ❖ Identified reason for placement termination	↑ Long-term placement of high-need consumers ↑ Consumer perceptions of service quality and competence	❖ HHSA LOCUS data ❖ Consumer satisfaction survey
Does the BCSP lead to increased access to support systems and providers inside Yolo County for Board and Care residents?	❖ # of service referrals ❖ # of service encounters ❖ # of support system contacts	↑ Service engagement ↑ Consumer perceptions of support system involvement	❖ HHSA utilization data ❖ Consumer survey

The BSCP will employ a pre/post mixed-methods study design to evaluate changes in Yolo County's understanding of factors contributing to Board and Care shortages. In addition, evaluation activities will measure progress and successful development of the Phase II Plan outlining strategies informed from investigation findings. Evaluation methods will be administered before and after implementation activities. Data management and analysis methods will be determined based on the quality and quantity of data collected. Data points may include data gathered from focus groups, literature review, benchmarking research, workgroup meetings, HHSA data, and other data.

During Phase II: Implementation, evaluators will employ a pre/post mixed-methods study design to evaluate changes in program-level outcome measures among Board and Care bed facilities (to assess capacity and availability) and individual-level outcome measures among adults with SMI facing barriers in access to Board and Care residency (to assess perceptions and access). The target population demographics will be analyzed to assess characteristics of individuals facing barriers in access to Board and Care beds. In addition, the evaluation team will analyze process measure data to characterize and report on implementation activities. Yolo County will measure program success by engaging stakeholders in designing and executing an evaluation following 6-12 months of program and service implementation. Data points may include baseline and ongoing individual-level consumer data from wellness surveys, service utilization, and other data; these data will be obtained from HHSA, state licensing data, surveys, and other data sources as identified during the evaluation design.

Findings from evaluation activities will be reported to HHSA, partners, and stakeholders through interim reports. Interim reports will provide updates on program progress through process measures. Upon completion of the Board and Care Study Project, findings from overall evaluation activities, including pre/post data analysis, will be summarized in a final report to HHSA, partners, and stakeholders. The final report will summarize findings related to program process, program outcomes, collaboration partners, impact on overall mental health system, and resources (e.g., funding, staff) invested in the INN project. The final report will also serve as a documentation of the innovative practices implemented in the INN project, which can serve as a model for other counties in California to implement the approach within their jurisdiction. Successful outcomes would support broader implementation of the programs and services ultimately developed through the BSCP.

Contracting

Yolo County (HHSA) will utilize data from evaluation activities and stakeholder engagement activities to ensure continuous quality improvement throughout the project period. Yolo County will apply MHSA INN funds to support contracts to fulfill key roles and functions, as needed. Yolo County will keep contract partners informed of regulatory compliance policies relevant to the project.

Additional Information for Regulatory Requirements

Certifications

Certifications and assurance of compliance with MHSA Innovative Project regulatory requirements are documented in the Yolo County Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020*.

Community Program Planning

Yolo County conducted a Community Program Planning (CPP) process for its Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020* between September 2016 and February 2017. During the MHSA CPP process, stakeholders identified significant gaps around access and availability of Board and Care homes, particularly for adults with serious mental illness (SMI). Thus, community input from the MHSA CPP process informed the development of the Board and Care Study Project.

The community program planning team was led by Karen Larsen, Department of Health and Human Services Director; Sandra Sigrist, Adult & Aging Branch Director; Joan Beesley, MHSA Coordinator; and Resource Development Associates (RDA), a consulting firm with mental health planning expertise. In order to ensure the planning process reached a broad spectrum of stakeholders, the planning team employed the following outreach efforts: flyers, email distribution lists, phone calls, and announcements for the MHSA planning summit. Materials were made available in Spanish, when applicable. Stakeholders included individuals from a multiple communities, including homeless, LGBTQ, transitional age youth, youth, older adults, consumers, consumers' family members, peer support workers, county staff, Latino, and mental health providers. In addition, stakeholder input was gathered from individuals with a wide spectrum of affiliations including: government agency, community-based provider, law enforcement agency, education agency, social services agency, veterans' organization, and medical or health care organization. Furthermore, efforts were made to include participants throughout the County, including CPP activities and events held at different locations throughout the County and at different times of day to promote opportunities for participation.

The CPP incorporated a participatory framework to encourage buy-in and involvement from stakeholders including service providers, consumers, family members, other professionals likely to come into contact with people with mental health needs, and interested community members. Throughout the planning process, the planning team made presentations to the Yolo County Local Mental Health Board (LMHB) and Board of Supervisors (BOS), both of which reviewed and helped to refine the recommendations made by the MHSA planning team. All meetings of the LMHB and BOS are open to the public. All participants in the planning process were provided with feedback forms and comment boxes for RDA staff to use a guiding and input tool throughout the process. All forms were anonymous to protect participant privacy and confidentiality.

Yolo County's CPP was built upon the meaningful involvement and participation of mental health consumers, family members, County staff, providers, and many other stakeholders. The planning team

carried out a set of community meetings and information-gathering activities to engage stakeholders in all stages of the planning and strategy development process in order to ensure that the plan reflected stakeholders' experiences and suggestions. Planning activities and their corresponding dates are presented in the table below, followed by a detailed description of each activity.

The MHSA CPP was comprised of a variety of meetings and activities, as described in Table 3.

Table 3. MHSA Community Planning Activities and Dates, 2016 - 2017

Activity	Purpose
Community Meetings	
Kickoff Meetings (Local Mental Health Board, Board of Supervisors, MHSA Stakeholders)	The Kickoff Meetings provided information about the proposed planning process timeline, and to gather feedback about what was missing or suggestions to improve the proposed process.
Board and Committee Meetings	
Local Mental Health Board	Members of the Local Mental Health Board calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Community Corrections Partnership	Members of the Community Corrections Partnership calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Board of Supervisors	Members of the Board of Supervisors calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Needs Assessment	
Focus Groups	The focus groups gathered input from providers and community members about their experiences with the mental health system and their recommendations for improvement.
Leadership Interviews	The Leadership Interviews facilitated understanding of the types and levels of services in each system of care across MHSA components, access points into each system, referral pathways, and touch points with services outside of the mental health system.
Stakeholder Surveys	The Stakeholder Surveys collected information from a wider audience beyond the focus groups, including the Russian community, consumers and families, and parents with minor children.
Quantitative Data Analysis	HHSA provided data regarding services supported by MHSA funds. Quantitative data analysis was conducted to characterize the number and profile of persons served as well as outcomes.
Strategy Development	
System of Care and Component (i.e., Child/TAY, Adult/OA, CFTN, WET, INN) Summits	The System of Care Summits built on from the Leadership Interviews and Focus Group information to identify key mental health service needs, unserved and underserved populations and geographic areas, barriers to entry and ongoing access of mental health services, workforce shortages, and needs related to capital facilities and technology.

Community Report Back Meetings	The Community Report Back Meetings presented the results of the system of care summits to stakeholders.
Board of Supervisors Meeting	Members of the Board of Supervisors calendared CPP activities to discuss stakeholder feedback, strategic planning, and MHSA plan development.
Public Review Process	
30-Day Review Period (February 17, 2017 – March 20, 2017)	The 30-Day Review period allowed for a draft plan to be distributed to the Board of Supervisors, Local Mental Health Board, county staff, service providers, consumers and family members, and those whose email addresses are associated with the stakeholder listserv. A public notice was also submitted and published through The Davis Enterprise and The Woodland Daily Democrat newspapers, county website, paper copies at HHSA department headquarters in Woodland and other sites throughout Yolo County
Public Hearing (March 22, 2017)	Stakeholders were engaged to provide feedback about the Yolo County MHSA *Three-Year Program and Expenditure Plan 2017 – 2020* . Four stakeholders attended the public hearing, representing county staff, the local mental health board, and consumers and family members. The full MHSA plan document, which summarizes public comment, is available at: http://www.yolocounty.org/health-human-services/agency-information/mental-health-services-act-mhsa

CPP participants were trained on the specific purposes of MHSA INN projects during the MHSA Component Planning Summit, which followed the system of care and component planning summits and addressed WET, CFTN, and INN. In response to the recent regulatory changes to the PEI and INN components, RDA staff reviewed program alignment with the new MHSA regulations and discussed options to bring services into alignment. During this summit, RDA reviewed findings from the needs assessment in each of these areas as well as findings and recommendations that emerged from the two system of care planning summits. The MHSA component work session resulted in a set of consolidated ideas, programs, and recommendations for HHSA have considered in the feasibility analysis.

Primary Purpose of Proposed Project

The primary purpose of the Board and Care Study Project (BCSP) is to **increase assess to mental health services** by addressing underlying factors contributing to limited availability and access to Board and Care services in Yolo County. Findings from the BCSP will inform strategies to expand bed capacity in Board and Care facilities for adults with serious mental illness (SMI), particularly for residents placed in out-of-county Board and Care facilities. By building bed capacity for adults with SMI, Yolo County will increase access to services and increase the overall quality of county-system services, which will lead to improved measurable outcomes for adults with serious mental illness.

MHSA Innovative Project Category

The Board and Care Study Project (BCSP) will **implement an approach that is new to the overall mental health system**, which is one of the three approaches specified in CCR, Title 9, Sect. 3910(a). Using a novel data-driven approach for solving Board and Care bed capacity, Yolo County will develop the evidence base regarding major factors influencing Board and Care bed shortages.

Target Population

The Board and Care Study Project (BCSP) will target adults (individuals 18 and over) with severe and persistent mental illnesses who require Board and Care services, and face barriers in access to Board and Care beds. Target population demographic information may vary in age, gender identity, race, ethnicity, sexual orientation, and language. The BCSP will specifically focus on individuals currently or at risk of being housed in out-of-county Board and Care facilities. In addition, the BCSP will investigate individual-level and program-level factors influencing Board and Care facility shortages in Yolo County.

MHSA General Standards

The Board and Care Study Project (BCSP) reflects and is consistent with the following MHSA general standards set forth in Title 9 California Code of Regulations, Section 3320:

- **Community Collaboration**. The BCSP relies heavily on the engagement of County stakeholders in gathering the information needed to fully define the problem and its roots. Community members, consumers, and other stakeholders will participate actively in a collaborative approach to designing solutions and programs to address the identified challenges. Yolo County will coordinate with the MHSA system of care and Community Care Licensing to promote interagency collaboration. In addition, Yolo County will communicate and engage with consumers, consumers' family and friends, and Board and Care facility operators to promote community collaboration. The project will implement a set of community meetings and information-gathering activities to promote community collaboration in all stages of the planning and strategy development process.
- **Cultural Competence**. The varied demographic characteristics of County behavioral health consumers contribute to the need for culturally appropriate services and supports for these populations. This INN project will increase a consumer's ability to access relevant services by ultimately creating more Board and Care capacity inside Yolo County. By creating capacity for consumers to access Board and Care services in their community, consumers are able to remain part of their family and cultural systems. By remaining in close proximity to their loved ones and support system, consumers will be in an environment that is more culturally relevant to them. In addition, Yolo County will collaborate and engage with diverse community stakeholders in order to incorporate the diverse belief systems concerning mental illness, health, healing, and wellness that exist among different racial/ethnic, cultural, and linguistic groups into program planning.
- **Client-Driven:** The BCSP will gather input from consumers with higher level of need facing barriers in access to Board and Care beds. Information regarding consumers' experience and perceptions, gathered through evaluation activities, will inform development of strategies to alleviate Board

and Care facility shortages in Yolo County. The Final Phase II INN Plan will draw from consumer input for planning, procedures, and evaluation planning.

- **Family-Driven:** The BCSP targets adult population and does not include children in the scope of this project. Thus, this item does not apply to the proposed project.
- **Wellness, Recovery, and Resiliency-Focused**. The proposed INN program will ultimately provide increased capacity for consumers to live in Board and Care facilities inside Yolo County, increasing their wellness and contributing to their recovery. It also facilitates consumers to stay in their community of origin, which fosters resiliency, personal empowerment, social connections. Placement in a familiar environment, such as their community of origin, provides a more stable foundation for self-respect, self-responsibility, and self-determination than placement in an unfamiliar environment, such a neighboring county. Consumers' proximity to their community of origin will also address barriers of travel to their mental health services, which further promotes their wellness and recovery.
- **Integrated Service Experience for Clients and Families**. This INN project will increase consumers' ability to access relevant services within their community of origin, which promotes integration of services when providers are in closer proximity to the consumer. The project supports the capacity of providers to engage with each other collaboratively by allowing for consumers to receive mental health services and to also live at a Board and Care inside Yolo County, streamlining their service experience. In addition, community-based mental health services will be better able to coordinate comprehensive care for consumers with higher needs when the consumer is in closer proximity. Close proximity to providers and community-based services will help preserve relationships between consumers and mental health staff. Furthermore, consumers will have access to a full range of mental health services within their community of origin.

Continuity of Care for Individuals with Serious Mental Illness

Continuity of care for individuals with serious mental illness (SMI) involves a multi-method approach in a safe living space. Out-of-county placement directly interferes with continuity of care resulting in detrimental setbacks to consumers' recovery. Continuity of care and continuity of contact are both necessary components for successful consumer outcomes, and close proximity of consumers to mental health staff allows for more opportunity to maintain contact and build strong relationships. Consumers' out-of-county placements pose barriers when they must travel farther for mental health services. Furthermore, coordination between mental health staff is necessary to provide integrated, comprehensive services to individuals with serious mental illness; placement of consumers in out-of-county Board and Care facilities makes it more difficult for mental health staff to provide coordinated services. There are also difficulties that arise with Medi-Cal assignment resulting from out-of-county placement, which further contributes to decreased continuity of care. In order to promote continuity of care, the Board and Care Study Project will increase access to in-county Board and Care facilities for individuals with serious mental illness.

INN Project Evaluation Cultural Competence

Targeted actions will be made to ensure that consumers are represented in all phases of the planning process and evaluation activities. Yolo HHSA and provider staff will reach out to linguistically isolated communities, particularly for Yolo County's large Latino/Hispanic and Russian populations. Interpreters will be available at community meetings and flyers related to stakeholder engagement will be made available in Spanish and Russian. In addition, HHSA staff will reach out to the homeless and LGBTQ communities to identify potential participants to represent their respective communities' perspectives. Evaluation tools and planning tools will be vetted with minority groups represented in the target population or stakeholder group. Furthermore, planning activities and evaluation activities will request participants to complete an anonymous demographic form, which will gather information about participants' age, sexual orientation, gender identity, race/ethnicity, residency (e.g., urban or rural), and whether they identified as a consumer, family member, or service provider. Disparities revealed through evaluation findings will be addressed by modifying planning activities to increase meaningful stakeholder involvement across diverse populations.

INN Project Evaluation Meaningful Stakeholder Involvement

In order to ensure meaningful stakeholder participation in the planning activities and evaluation activities, the BCSP will rely on a workgroup formed from planners and stakeholders to support implementation and strategic planning. Stakeholders may include County staff, providers, consumers, and consumers' families. The workgroup will play a critical role for informing overall strategic and program planning, as well as evaluation planning and implementation. Evaluation findings will be communicated to stakeholders, and stakeholders will have the opportunity to contribute to their interpretation and provide input on reports. HHSA will also provide training and technical assistance to the workgroup throughout the project to support meaningful stakeholder participation.

Project Continuation Without INN Funds

The purpose of this project is to engage in research that provides a more robust understanding of the factors contributing to the Board and Care shortage in order to identify strategies to increase Board and Care capacity within the County. If the strategies identified are appropriate for INN funding, the County will work with the MHSOAC to obtain approval for Phase II of this project. However, HHSA may discover strategies throughout the course of this project that are likely to be effective but may not be innovative. To that end, Yolo County has committed to implementing the strategies identified and prioritized through the BCSP with whatever funding is most appropriate for the actions identified. HHSA will leverage existing financial and programmatic resources to fund a portion of the implementation activities after MHSA INN funds are no longer available.

Communication and Dissemination Plan

Yolo County will develop a final report summarizing findings from the Board and Care Study Project, including study results and newly identified strategies. The report will be shared with MHSA stakeholders, including County staff, providers, consumers, and consumers' families.

The final phase of the BCSP involves development of an implementation plan which outlines implementation activities informed by the findings of the BCSP. The plans for the newly developed program will be detailed in the Phase II INN Plan. Yolo County will communicate the Phase II INN Plan and engage with consumers, consumers' families, and Board and Care facility operators to promote community collaboration during program planning. MHSA stakeholders will play an integral in disseminating findings (from the BCSP as well as the Phase II INN Plan) to contacts within and outside of Yolo County. Dissemination methods may include website, published reports, and email distribution. Keywords for searches related to the BCSP include the following terms or phrases: Board and Care innovation; Board and Care bed capacity; Board and Care for adults with serious mental illness; and Board and Care in Yolo County.

Timeline

The Board and Care Study Project (BCSP) will be conducted over a six month period, between July 2017 and December 2017. The following timeline provides a detailed breakdown of planned activities for the BCSP (Table 4).

Table 4. Board and Care Study Project Timeline, July 2017 – Dec 2017

	Project Month					
Milestone/Deliverable	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Phase 1: Project Launch						
HHSA Kickoff meeting	■					
Board and Care Workgroup Preparation	■					
Board and Care Workgroup Kickoff Meeting (1)	■					
Phase 2: Data Collection and Analysis						
Quantitative Data Request and Analysis	■					
Qualitative Data Collection and Analysis	■					
Benchmarking Research	■					
Literature Review	■					
Board and Care Workgroup Meetings (2)		■	■			
Phase 3: Program Development						
Concept Paper Development				■		
Board and Care Workgroup Meetings (2)				■	■	
Phase 4: Phase II INN Planning						
Draft Phase II INN Plan – Board and Care Implementation Plan					■	■
Board and Care Workgroup Meetings (1)						■
Final Phase II INN Plan – Board and Care Implementation Plan						■
Consultation with MHSOAC						■
Presentation to MHSOAC						■
Ongoing Project Management and Communication						
Project Management	■	■	■	■	■	■
Communications	■	■	■	■	■	■

The timeline below outlines planned activities and milestones for Phase I and Phase II during the four-year period, between July 2017 and July 2021 (Table 5).

Table 5. Timeline for Strategy to Address Board and Care Shortages, July 2017 – July 2021

	Year 1				Year 2				Year 3				Year 4			
Milestone/Deliverable	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Phase I: Board and Care Study Project																
Project Launch	■															
Data Collection and Analysis	■	■														
Program Development		■														
Phase II INN Planning		■														
Select Evaluator	■															
Plan Evaluation Design	■															
Conduct Evaluation Activities	■	■														
Interim Reports on Evaluation Findings	■	■														
Final Report on Evaluation Findings		■														
Distribute Phase II INN Plan		■														
Phase II: Implementation																
Seek Funding Sources			■	■												
Implementation Activities				■	■	■	■	■	■	■	■	■	■	■	■	■
Select Evaluator			■													
Plan Evaluation Design			■													
Conduct Evaluation Activities				■	■	■	■	■	■	■	■	■	■	■	■	■
Interim Reports on Evaluation Findings				■	■	■	■	■	■	■	■	■	■	■	■	■
Annual Report on Evaluation Findings								■				■				
Final Report on Evaluation Findings								■				■				■

Project Budget

INN Project Budget and Source of Expenditures

A. Budget Narrative:
Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

BUDGET NARRATIVE FOREWORD:

Initially, the Yolo County Innovation program proposal targeting the county's shortage of Board and Care facilities to accommodate its Seriously Mentally Ill (SMI) clients was planned as a three-year INN project. On the recommendation of MHSOAC staff, Yolo will be conducting a one-year Study Project before initiating the program. The Board and Care Study Project seeks to achieve the following learning goals: (1) increase understanding of the dynamics underlying the Board and Care bed shortage; (2) identify strategies and incentives to increase Board and Care bed capacity; (3) identify capacity-building approaches to incentivize the placement of consumers with the most intense service needs in available Board and Care beds; and (4) develop an implementation plan to increase access to Board and Care placement for those with the most intense service needs.

The budgets outlined below are intended to reflect the costs of conducting the one-year Board and Care Study Project in FY 17-18, and then, a very rough estimate of a program based on the information gathered from the study goals detailed above. Suffice it to say that budgets for years two and three included here should be considered general and preliminary, and they will need to be reformulated once the Board and Care Study Project is complete. Higher consultant costs in year one are reflective of the plan to complete the study project before going forward with the program; consultant costs in years two and three are attributed to program evaluation.

Budget Narrative:

Section B.

1. $38,750 in FY 17-18 represents salary and benefits for 0.1 FTE Program Manager and 0.1 FTE Analyst; costs may increase in years two and three of the project.
2. N/A
3. $11,625 in FY 17-18, $11,925 in FY 18-19 and $11,936 in FY 19-20 represents administrative costs at 15%.
4. Total
5. N/A
6. N/A
7. N/A
8. N/A
9. N/A
10. N/A
11. Annual cost of $38,750 in FY 17-18 represents consultant fees to assist with Board and Care Study; consultant fees for FY 18-19 of $23,850 and $23,872 in FY 19-20 represent anticipated costs of program evaluation.
12. N/A
13. Total
14. Program costs are estimated at $0 for FY 17-18 (program study); on the assumption that a program will be implemented after the study, program related costs of $15,900 are anticipated in FY 18-19 and $15,915 in FY 19-20.
15. N/A
16. Total

Section C.

Part A.

A.1 $11,625 in FY 17-18, $11,925 in FY 18-19 and $11,936 in FY 19-20 represents estimated administrative costs at 15%.
A.2 N/A
A.3 N/A
A.4 N/A
A.5 N/A
A.6 N/A Total

Part B.

B.1 Consultant costs of $23,850 in FY 18-19 and $23,872 in FY 19-20 represent anticipated costs of program evaluation.
B.2 N/A
B.3 N/A
B.4 N/A
B.5 N/A
B.6 Total

Section C., Continued.

Part C.

C.1 Total MHSA INN funds for FY 17-18 is estimated at $89,125; total MHSA INN funds for FY 18-19 is estimated at $91,425; total MHSA INN funds for FY 19-20 estimated at $91,511; 3-year total is anticipated at $272,061.

C.2 N/A

C.3 N/A

C.4 N/A

C.5 N/A

C.6 Total

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Salaries	**38,750**	**39,750**	**39,788**			**118,288**
2.	Direct Costs						
3.	Indirect Costs	**11,625**	**11,925**	**11,936**			**35,486**
4.	Total Personnel Costs						
		50,375	**51,675**	**51,724**			**153,774**
OPERATING COSTs		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						

NON RECURRING COSTS (equipment, technology)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
11.	Direct Costs	**38,750**	**23,850**	**23,872**			**86,472**
12.	Indirect Costs						
13.	Total Consultant Costs	**38,750**	**23,850**	**23,872**			**86,472**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
14. Program related expenses		**15,900**	**15,915**			**31,815**
15.						
16. Total Other expenditures		**15,900**	**15,915**			**31,815**

BUDGET TOTALS						
Personnel (line 1)	**38,750**	**39,750**	**39,788**			**118,288**
Direct Costs (add lines 2, 5 and 11 from above)	**38,750**	**23,850**	**23,872**			**86,472**
Indirect Costs (add lines 3, 6 and 12 from above)	**11,625**	**11,925**	**11,936**			**35,486**
Non-recurring costs (line 10)						
Other Expenditures (line 16)		**15,900**	**15,915**			**31,815**
TOTAL INNOVATION BUDGET	**89,125**	**91,425**	**91,511**			**272,061**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*

Administration:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 17-18	FY 18-19	FY 19-20	FY xxxx	FY xxxx	Total
1.	Innovative MHSA Funds	**11,625**	**11,925**	**11,936**			**35,486**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**11,625**	**11,925**	**11,936**			**35,486**

Evaluation:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 17-18	FY 18-19	FY 19-20	FY xxxx	FY xxxx	Total
1.	Innovative MHSA Funds		**23,850**	**23,872**			**47,722**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**23,850**	**23,872**			**47,722**

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 17-18	FY 18-19	FY 19-20	FY xxxx	FY xxxx	Total
1.	Innovative MHSA Funds	**89,125**	**91,425**	**91,511**			**272,061**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**89,125**	**91,425**	**91,511**			**272,061**

*If "Other funding" is included, please explain.

Yolo County MHSA FY 2017-2020 Innovation Program Plan Description

First Responders Initiative

Prepared by:

Resource Development Associates

April 27, 2017

First Responders Initiative

Executive Summary

In 2013-14, Yolo County Health and Human Services Agency (HHSA) engaged in a Community Program Planning (CPP) process to develop its MHSA Three-Year Program and Expenditure Plan for 2014-2017. As a part of the planning process, stakeholders identified gaps in the crisis continuum of care as a critical need. To address this need, HHSA applied for and received Mental Health Services Act Oversight and Accountability Commission (MHSOAC) Triage Grant funding to develop the Crisis Intervention Program (CIP) that provides clinical staff to respond to mental health crises in partnership with five law enforcement agencies in the County. The CIP program has been successful in 1) avoiding unnecessary Emergency Department (ED) and psychiatric hospitalization for persons served, and 2) building LEA capacity to respond to mental health emergencies and increasing collaboration between HHSA and LEAs. During this most recent CPP process to develop the MHSA Three-Year Program and Expenditure Plan for 2017-2020, stakeholders acknowledged CIP's successes and identified the need to 1) expand the collaboration and capacity beyond LEAs to address mental health crises and 2) develop alternative drop-off locations for people who do not need emergency intervention but are too acute to remain where they are.

As such, HHSA and stakeholders developed the First Responders Initiative, which has three primary components.

1. **Multidisciplinary Forensic Team (MDFT):** HHSA plans to modify the existing MDFT practice that exists in other California counties of facilitating a regular, ongoing case conference between LEAs and behavioral health staff to include all first responders (i.e. EMS, EDs, and fire). The purpose of the modified MDFT is to gather all emergency personnel who may encounter someone experiencing a mental health crisis with HHSA and contracted providers to develop a coordinated response for individuals who are likely to come into contact with first responders or have a history of repeated contact.
2. **Mental Health Urgent Care (MHUC):** Currently, LEAs and other first responders only have one option for people experiencing crisis who cannot remain where they are, which is transportation to the ED. HHSA has explored the feasibility of a Crisis Stabilization Unit (CSU), but has determined that the County is too small to support a 24/7 CSU. Instead, the County has designed a MHUC program that can provide crisis intervention services to individuals and their families who do not

meet criteria for a 5150 hold but require additional support. This also provides an additional location for first repsonders to drop off someone in need of mental health support; the facility also plans to accept walk-ins and family members dropping someone off, thereby providing an alternative to the ED for consumers and their families.

3. **Health Information Exchange:** HHSA and the EDs each maintain their own Electronic Health Records (EHRs), and each of the LEAs and first responder agencies maintain separate dispatch and call records. In order to support a coordinated response for people with frequent contact with first responders, EDs, and HHSA crisis and other behavioral health services, HHSA and partners have identified a need to support health information sharing. Recognizing that this is a significant investment of time and resources, HHSA has reached out to the ED partners and health plans to begin the process of including this project as a part of a larger HIE initiative, currently underway.

To this end, Yolo County is interested in learning how the MDFT, MHUC, and HIE components and the First Responders Initiative (FRI) initiative deepen shared understanding of the extent to which the FRI 1) reduces the avoidable use of ED, hospital, and jail admissions for people with serioue mental illness, 2) increases access to planned and ongoing mental health services following a crisis event, 3) promotes wellness and recovery for people experiencing a mental health crisis, and 4) promotes and strengthens collaboration amongst HHSA, behavioral health providers, and first responders (i.e. LEAs, EMS, EDs, and fire) as well as between consumers and providers. This project is a collaborative public and private partnership that respresents a commitment amongst all participating agencies as well as the County, HHSA, and stakeholders to continuously improve crisis services, promote collaboration, and ensure that Yolo County residents have access to coordinated, quality services during and following a crisis event.

County:	Yolo County
Project Name:	First Responders Initiative
Date Submitted:	April 27, 2017

Project Overview

Primary Problem

Yolo County, with its distinct geographic, cultural, and socioeconomic characteristics, has the unique challenge of providing services to diverse groups and communities that are also geographically varied. Services must contend with the need for flexible service delivery, cultural competency across groups, transportation, and access across a vast territory.

Yolo County currently utilizes partnerships between law enforcement and mental health professionals to provide prompt, evidence-based, mobile crisis services to consumers in the community. Though initial response services are strong, when first responders encounter someone experiencing a mental health crisis the options for intervention are limited to supporting the person to remain where they are or transporting them to the emergency department (ED). If the person has a co-occurring disorder and is in possession of substances and/or paraphernalia, or if they are suspected of committing a crime, they may also be arrested and taken to jail. If taken to the ED, discharge options after business hours are limited in that the person may either be discharged back to the community, hospitalized, or referred to crisis residential services. During the 2017-2020 Yolo County MHSA Three-Year Plan Community Program Planning (CPP) process, stakeholders identified these gaps in both the disposition options available to psychiatric emergency responders, as well as in connecting people transitioning from hospitals and/or jails to mental health services beyond the immediate crisis instance.

During this CPP process, stakeholders expressed a wish to solve these issues by better integrating non-law enforcement first responders into the larger mental health team, and by providing an additional option for them to intervene in a crisis besides leaving consumers where they are or taking them to the ED. The proposed Innovation plan seeks to alleviate both of these issues, the first by modifying the multi-disciplinary forensic team (MDFT) model to incorporate Yolo County's non-law enforcement first responders. The project will address the second issue by also creating a short-term, supportive drop-in urgent care center where first responders can transport consumers who are not able to remain where they are but do not need to go to the ED or do not meet criteria for an involuntary hold.

What Has Been Done Elsewhere to Address Your Primary Problem?

Literature and Existing Practices Review

Methods

As the innovative component of the proposed program focuses on the MDT modification, the literature and existing practices review concentrated on this topic. We primarily focused on the current body of knowledge regarding multidisciplinary teams (MDTs) in general and multidisciplinary forensic teams specifically (MDTs incorporating law enforcement) as the closest models to the proposed Innovation, and then searched for information on MDTs that utilize non-law enforcement first responders. Our secondary focus was empirical research and current practices supporting Mental Health Urgent Care Centers (MHUCs). The goal of the literature and existing practices review was to gain a thorough understanding of how MDT meetings are used in a variety of settings applying to Yolo County, and to help formulate an efficient, effective structure for the proposed MDFT and accompanying MHUC.

Findings

General literature supporting the practice of multidisciplinary teams abounds, but the law enforcement modification (multidisciplinary forensic teams, or MDFTs) do not have a strong peer-reviewed research base. Instead, support for this modification is mainly descriptive of MDFT structure, process, anecdotal consumer results, and professional efficiency. In contrast to MDT literature and MDFT practices, multidisciplinary non-law-enforcement (non-LE) first responder teams do not appear in either the peer-reviewed literature or as an existing practice.

MDT Research Base

Multidisciplinary teams are commonly used in contexts where applying a diversity of resources, knowledge, skills, and abilities to case planning and treatment is beneficial. There are several uses for the term "multidisciplinary team," spanning informal day-to-day working arrangements to carefully designed, formalized, and scheduled meetings between members who work in different roles and for different organizations to review cases and create and update intervention plans. The First Responders Initiative intends to use the latter structure, and the research and practices discussed below refer to this type of MDT.

Liberman et. al describe MDTs as "[combining] the expert contributions of professionals and paraprofessionals who can individualize a comprehensive array of evidence-based services with competency, consistency, continuity, coordination, collaboration, and fidelity."[1] The core principle behind the model is that consumers who receive multiple services from different providers with complimentary but separate disciplinary perspectives benefit when those providers meet to coordinate services.

[1]Liberman, R. P., Hilty, D. M., Drake, R. E., & Tsang, H. W. (2001). Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation. *Psychiatric Services*, 52(10), 1331-1342. doi:10.1176/appi.ps.52.10.1331

Regardless of overarching goal, context, and specific group composition, MDTs are comprised of members from different professional fields and organizations and typically meet in intervals ranging from once per month to weekly to review cases and create or modify a treatment or intervention plan. Though MDT practices appear to be similar regardless of end goal, note that most of the research base refers to MDTs in the context of medical treatment.

The literature suggests recommendations regarding MDT specifics around philosophy, size, composition/roles, core competencies, non-case activities, tools, and resources.

Philosophy: Another important aspect of effective MDTs is a membership that shares a common philosophy in the care of consumers that is flexible enough to customize their philosophy to the needs of the individual[2]. Teams that are not unified in their philosophy and approach may struggle to create effective plans for the people they serve, as when philosophy is not in alignment, not all members will be invested in adhering to the plan agreed upon by the MDT.

Size: The literature around MDTs advises careful thought around the size of the team, as diversity of disciplines and number of people in attendance is not proportional to effectiveness[3]. Other factors are more critical to the effectiveness of the team, specifically ensuring that the team is compromised of the right membership. Size is also a factor in considering: 1) the logistical burden of arranging for the meeting, 2) the number of cases that the team is expected to work with, 3) issues around team building activities, and 4) training needs/delivery.

Composition/roles: Staffing by the most appropriate providers working within a clearly defined set of objectives and relevant roles is one of the most important factors in the success of an MDT[4]. In successful MDTs, participants who are critical to meeting the goals of the team, as well as members who are mandated to be part of the team, are considered "core members." These members attend all meetings, or ensure that an appropriate replacement attends in their place. In addition, the MDT Coordinator, MDT Facilitator, and— when appropriate— Key Worker play critical roles; on smaller teams, these roles may overlap. The Coordinator is responsible for administrative duties related to the scheduling and logistics of the team and its activities, whereas the Facilitator runs the meeting itself.[5] When a Key Worker is used,

[2] Orovwuje, P. (2008) Contemporary challenges in forensic mental health: The ingenuity of the Multidisciplinary team. *Mental Health Review Journal*, 13(2), pp. 24–34.
[3] Fay, D., Borrill, C., Amir, Z., Haward, R. and West, M. A. (2006), Getting the most out of multidisciplinary teams: A multi-sample study of team innovation in health care. *Journal of Occupational and Organizational Psychology*, 79: 553–567.
[4] Nic a Bháird, C., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N. and Raine, R. (2016) Multidisciplinary team meetings in community mental health: A systematic review of their functions. *Mental Health Review Journal*, 21(2), pp. 119–140.
[5] Fisher, T., Fontenot, G., and Woodcock, N. (2012) A Collaborative Approach to Multidisciplinary Teams in Sonoma County. *County of Sonoma, Human Services Department*, Adult and Aging Services Division.

their task is to act as a main point of contact for the consumer, through which most of the care services are coordinated[6].

Core competencies: Complimentary to issues around composition and roles, MDTs focusing on mental health require specific competencies. In 2006, the Mental Health Commission (Ireland), adapted 1997 guidance from another agency and listed these competencies as, "assessment, treatment and care management, collaborative working, management and administration, and interpersonal skills."[7] There is no expectation that all members be equally proficient in all of these competencies or that they bring the same perspective to operationalizing them. Instead, these competencies are most important in creating a shared language and basic level of understanding to create plans that can be operationalized by all members.

Non-case activities: Trainings, team-building, data gathering and other activities that do not directly relate to consumer care also have a traditional place in the MDT model. Though there have been mixed results in the literature regarding the effectiveness of non-case activities, specifically trainings, some studies have found there to be improvements to MDTs resulting from these.[8]

Tools: Developing tools for team processes allows for a certain degree of process standardization, and theoretically increases MDT efficiency and improves the depth and quality of program evaluation. However, a review of relevant literature around the relationship of tool use on team effectiveness was conducted by Buljac-Samardzic et- al., which found that though tool use had a positive effect on communication and team unity, the quality of the evidence supporting the effect was quite low[9]. This suggests that in the evaluation of this project, special attention paid to the evaluation of MDT tools would contribute to general learning in this area.

Resources: Most research does not speak specifically to resource allocation and funding for MDTs, but one source focused upon MDT in the adult protective services field noted that most resources allocated were in-kind, generally in the form of staff time[10]. Though most MDTs do not receive abundant direct funding, this support is useful in providing opportunities for members to develop professionally, such as by attending trainings and conferences.

MDT/MDFT Existing Practices

In California, the use of MDFTs to serve justice-involved mental health consumers originated in Marin County in 1999. Since that time, other counties have modified the Marin model to suit their local needs,

[6] Multidisciplinary Team Working: From Theory to Practice: Discussion Paper. (2006). *Mental Health Commission*. Retrieved from http://www.mhcirl.ie/File/discusspapmultiteam.pdf
[7] *Mental Health Commission*, 2006.
[8] Buljac-Samardzic, M., Doorn, C. M., Wijngaarden, J. D., & Wijk, K. P. (2010). Interventions to improve team effectiveness: A systematic review. *Health Policy*, 94(3), 183-195.
[9] Buljac-Samardzic et. al., 2010.
[10] Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A National Look at Elder Abuse Multidisciplinary Teams. *Journal of Elder Abuse & Neglect*, 15(3-4), 91-107.

either in a purely mental health context or, as in San Francisco and Sonoma Counties, specifically around adult protection. Multiple California counties also utilize the MDT model in child protection. MDT is by no means localized to California, however, and is an established and accepted practice in other locations worldwide, such as the UK and Ireland. Regardless of location, generally MDT is structured into four steps:

1. *Intake and Assessment*. Once the MDT Coordinator receives a referral, the consumer is evaluated for key areas of need utilizing a broad assessment of all life areas. There may or may not be specific criteria for acceptance beyond meeting the general mission of the MDT.
2. *Presentation*. Following completion of the assessment, the consumer's case is presented to the MDT for review and, if a Key Worker is used in the model, one is allocated based on the specific needs of the consumer. The Key Worker collaborates with other team members to coordinate deeper assessments for the consumer as appropriate.
3. *Care Plan*. Either immediately or following further completed assessments, the case is presented for action at the MDT. The MDT formulates a unified plan for the consumer, which is accessible to all team members.
4. *Review*. Once goals, actions, person(s) responsible, and date of each goal's review are established, a formal review date is set. In the time between the establishment of the Care Plan and the formal review date, the key worker coordinates with other team members to provide care for the consumer according to the plan requirements[11],[12].

MDFTs integrate law enforcement into the MDT model to best plan for and serve consumers who frequently interact with law enforcement. These teams plan specifically for handling crises or emergencies from the perspective of law enforcement. The principle underlying the use of the MDFT is that law enforcement is in frequent contact with mental health consumers, but that as a standalone, is unable to provide ongoing care and often has limited choices about how to respond to these situations. When a consumer is experiencing a crisis that is too acute to remain in the community but does not currently reach the threshold of a psychiatric hold, responding law enforcement often feel they have little alternative than to involve consumers with the criminal justice system[13]. To help alleviate this issue, law enforcement integrated into the MDT model provide their perspectives and support to the team, form stronger connections to mental health colleagues, refine their skills with mental health consumers in general, and become more planful around interactions with the specific consumer at hand.

One main difference between MDTs and MDFTs is the definition of success: in the Marin County MDFT model, success is defined as resolving the legal issue and linking a consumer to the appropriate mental

[11] *Mental Health Commission*, 2006.
[12] Todt, J. *Mental Health and Law Enforcement Working Together*. Retrieved from California Institute for Behavioral Health Solutions Web Site: http://www.cibhs.org/sites/main/files/file-attachments/thurs_215_edge_c_community_based_todt.pdf
[13] Police-Medical Collaboration: Dealing With Mental Health. (2015). *California State Association of Counties*. Summary Notes and Resources: Conversations on the Emerging Issues. Retrieved from http://www.counties.org/sites/main/files/file-attachments/police-medical_collaboration.pdf.

health services. Additionally, in this model, no referral to the team is rejected and none are closed until success is achieved[14].

First-Responder Enhanced MDT

We were unable to locate existing literature or practices in another location specifically addressing the addition of non-law enforcement first responders to the MDT; however, in researching to support this program, we consider the MDFT model to be an adequate allegory for the FRI MDT. The limitations applying to law enforcement and non-law enforcement first responders are similar; the only substantive exception to this is that law enforcement first responders have the option to take consumers to jail or the hospital, whereas non-law enforcement first responders are unable to take consumers in crisis to jail.

Though it has not previously been tried, the FRI MDT practice would be allowable under the same section of the law that allows for MDFTs: "(2) (A) Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons." [15]

Mental Health Urgent Care

Though not an innovative practice, the Mental Health Urgent Care (MHUC) is integral to the FRI. It provides a location for first responders and community members alike to bring consumers who need structured support but do not meet criteria for a psychiatric hold. As a "no refusal drop-off site," a MHUC would not only support consumers but also allow first responders to return to their duties more quickly than if they bring the consumer to the ER or take them to jail.[16] The MHUC model is used in various locations nationally and globally, and is an accepted practice.

Proposed Project

During the CPP process for the Yolo County MHSA Three-Year Program & Expenditure Plan for 2017-2020, stakeholders acknowledged the group of individuals throughout the County who have repeated, regular contact with first responders, including at EDs. The local Crisis Intervention Program (CIP) is an effective and critical program serving this population, but it is limited by geography, operating hours, and participating agencies. The MHUC aspect of the First Responders Initiative (FRI) will not be limited by these factors, creating an option for consumers that may involve first responders but does not require their involvement to access services.

As access to MHUC services will not be limited by referral source, consumers will be able to receive the support they need with fewer limitations. However, recognizing that first responders are likely to be involved most of time, the FRI simultaneously presents an opportunity for the MDT component of the

[14] ibid
[15] California WIC § 15633(2)(A).
[16] Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services*, 52, 219–222.

program. The MDT will assist first responders in proactively identifying these individuals and developing shared plans for the next first responder contact to divert them from EDs, jail, and hospital stays.

The First Responders Initiative (FRI) responds to these two complimentary needs by:

1. Improving collaboration and information sharing between non-law enforcement first responders, other service providers, and consumers;
2. Strengthening the shared ability of first responders to address immediate needs and divert people who do not require an involuntary hold or incarceration to another alternative space; and
3. Providing a safe, supportive location for consumers when experiencing a crisis too acute to remain in the community, yet not acute enough to require hospitalization.

The FRI responds to these needs by creating two complimentary services and participation in a Health Information Exchange (HIE) to facilitate real-time data sharing. First, the FRI modifies the forensic multidisciplinary team (MDFT) model currently used in other California counties and abroad to integrate non-law enforcement first responders such as EDs, EMS/paramedics/fire, dispatch, and CIP homeless outreach staff into a multidisciplinary team. Second, the FRI establishes a Mental Health Urgent Care center, which may be co-located with a community-based drop-in navigation center, to provide a new alternative for consumers in crisis in Yolo County. The MHUC provides a safe space to meet the immediate stabilization needs of consumers while also providing opportunities for linkages to further services after the immediate incident has resolved.

Services Description

This project builds upon the well-established practice of the multidisciplinary team model, specifically the MDFT, and reacts with a first responder innovation specific to the identified needs in Yolo County. Though the FRI features two new services to Yolo County, the first-responder enhanced MDT and the Mental Health Urgent Care (MHUC), only the former is an innovative strategy. Though MDFTs are used in various locations, non-law enforcement first-responder membership is innovative.

The FRI will improve consumer recovery outcomes by: 1) interrupting the cycle of first response calls that result in removal from the community, 2) combining the FRI with the MHUC resources to provide a safe alternative to the ED, and 3) increasing intervention skills and knowledge for non-law enforcement first responders.

First-Responder Enhanced MDT

The Yolo County FRI rests on the concept of the First-Responder Enhanced MDT. The MDT will meet ona twice-monthly basis; in the initial stages while a base of consumer cases is being developed, there will be sufficient time in the meetings to conduct initial trainings; reach shared working agreements; make assignments regarding the development of policies, procedures, tools; and to review all of these elements. Specifics regarding these activities will be partially dependent upon the needs of the membership; for

example, if the first responders placed on the MDT have limited mental health training, additional education will be provided according to their individual needs.

The First-Responder Enhanced MDT will follow the established, current practice structures outlined in the Literature and Existing Practices Review discussed above, in order to create an effective, collaborative structure to meet the needs of Yolo County mental health consumers.

Mental Health Urgent Care

The Mental Health Urgent Care is also a critical component of the FRI. Consumers with a mental health need that do not meet criteria for a psychiatric hold and who are willing to accept help voluntarily would have access to the MHUC, where they could de-escalate and receive a variety of supportive services. As part of the plan developed during the MDT meeting, a WRAP plan, or on an *ad hoc* basis, first responders and loved ones will have the option to bring a consumer to the MHUC instead of the ED. Consumers themselves can also utilize services on a walk-in basis.

MHUC services represent a significant expansion of service scope and availability for this consumer population, who previously relied heavily upon the Crisis Intervention Program (CIP) for community-based intervention. Though highly valuable, the CIP is more limited in service hours than the FRI and is subject to participating agency availability, and the only options available for CIP responders are to transport consumers to the hospital or leave them where they are. The MHUC represents a third option for providing support to consumers and would operate 12-16 hours per day, 7 days per week. The MHUC will offer the following services:

- **Intake Assessment**. MHUC staff will provide an assessment at intake to understand the current crisis situation, what led up to the crisis, and other relevant information about the person's history and needs. As permitted by existing privacy laws, family members and other loved ones may participate to provide information about the consumer, the current crisis, and their understanding of need.
- **Crisis Intervention Counseling**. Staff will provide support in resolving the current crisis, identifying and planning around what led up to the crisis, and arranging follow up services to address immediate needs (e.g., CRT, shelter). This may include one-on-one and, as appropriate, family counseling to consumers and their loved ones. Counseling services will be designed to alleviate the current crisis and to avoid escalation to hospitalization, promoting a safe return to the community.
- **Peer support**. Peer support staff will provide structured and floating support to consumers to resolve the crisis, practice in-vivo coping skills, and developing a Wellness Action Recovery Plan, particularly as it relates to recognizing the early signs and symptoms of a crisis as well as coping skills the consumer may choose to implement and other supports that may be helpful in a crisis.
- **Limited medication support**. The MHUC will have an on-site Nurse Practitioner who can prescribe medications. Substantive counseling or medication support beyond what can be safely provided

at the MHUC will trigger referrals to the appropriate services, but the on-site services will provide consumers with refills and new medications as needed to stabilize the current situation.

- **Groups and activities**. Groups and activities at the MHUC will be focused around providing coping skills, WRAP, and creating supportive individual interactions to assist the consumer in resolving their immediate need.
- **Discharge Planning**. Based on an assessment of the current crisis and the consumer's needs and resources, staff may arrange follow up appointments and referrals to supportive services.

In order to encourage community buy-in and consumer willingness to attend the MHUC as needed, the facility will hold periodic open houses so that consumers, families, and professionals can learn about the MHUC and its services. Additionally, the MHUC will further raise awareness by performing outreach to community organizations who interact with consumers who may benefit from MHUC services.

Implementation Considerations

Implementation considerations for the FRI are three-fold: those that involve the launch of the MDT, those that involve the launch of the MHUC, and those that apply to both components.

MDT considerations include:

- **Forming the MDT membership**. Criteria for all members on the MDT will be developed according to the research and current practices discussed above around appropriate membership, including non-law enforcement first responders.
- **Establishing working guidelines**. According to research and best practices, before implementing the MDT guidelines must be created to guide the work and to provide context to the team, including written interagency agreements.
- **Training**. Individuals identified for membership on the MDT will be provided with relevant training before becoming active on the MDT.
- **Implementing the MDT.** During the first 30 months of implementation, ongoing as well as interval process and outcome studies will be performed to provide continuous quality improvement to the project. Any factors that have shown to limit implementation scope or program capacity will be carefully evaluated and considered during implementation, and modifications will be made as necessary.

MHUC considerations include:

- **Identifying a service provider**. Utilizing the standard County process for creating a Request for Proposals and evaluating proposals submitted, Yolo County will select a service provider for the MHUC.
- **Obtaining space and staff**. The MHUC may be be co-located with one of the County's new navigation centers, if possible once the navigation center spaces are secured. The space requires welcoming common areas for consumers in the mental health urgent care setting. Staff will

include a Clinical Manager, Assistant Clinical Manager, Peer Support workers, non-medical mental health professional staff such as social workers and counselors, a Public Health Nurse, and support staff.

- **CUP and Medi-Cal Certification**. The MHUC will need to obtain the appropriate conditional use permits, if needed, and Medi-Cal certification as an outpatient clinic to allow for crisis intervention service billing for eligible staff and services.
- **Training**. Before the MHUC opens, all staff will need to be trained on processes as well as policies and procedures, and first responders will also need to be trained on when bringing a consumer to the MHUC is appropriate.
- **Raising awareness**. As discussed above, before opening, during initial stages of operation, and on an ongoing basis, the MHUC will perform community outreach to consumers, families, and relevant local service organizations to raise awareness in the community around the new services and alternatives that the MHUC will offer.

Some considerations apply to both components of the project:

- **Establishing policies, procedures, and parameters**. Parameters, including policies and procedures, will be developed prior to the implementation of the FRI as appropriate for both components of the project. These will be continually developed and updated as part of an ongoing Continuous Quality Improvement (CQI) effort.
- **Privacy Issues**. Both the MDFT and HIE components of this project require sharing of protected health information under HIPAA and 42CFR. The County plans to work with partners and counsel to consider ways to ensure compliance with state and federal law regarding health information sharing and may seek guidance from other jurisdictions with active MDFT and HIE programs that have fully developed and implemented privacy guidelines for these activities.

Innovative Component

First Responders Modification

The multi-disciplinary forensic team (MDFT) is a robust practice that provides a treatment team integrating law enforcement and multiple other disciplines (often psychiatry, social work, nursing, occupational therapists, etc.) in support of community members with identified mental health needs who have frequent interactions with the criminal justice system. Traditionally, the MDFT model excluded non-law enforcement first responders such as EMS/paramedics/firefighters and EDs; FRI will utilize an MDT approach similar to the MDFT, but including non-law enforcement first responders in order to meet the needs of consumers who frequently interact with EMT/paramedics and fire services.

The FRI model will bridge the gap stakeholders repeatedly identified during the CPP process between first response services and mental health services by integrating non-law enforcement first responders into MDT teams. The purpose of the modification is for the MDT to be able to respond to the needs of consumers who frequently interact with all first responders due to mental health crises. The MDT,

including the first responders, will create a unified intervention plan for the consumer that provides for future encounters.

Learning Goals/Project Aims

Implementation of integrative care via multidisciplinary team approaches has been shown to have positive impacts on health outcomes and behavior changes when used in the management of complicated mental health conditions. The aim of this integration is to improve the experience of the consumer while engaging with a first responder in a crisis situation. This program meets Innovation criteria by adapting the proven MDFT approach and adding other groups to the team that have not previously been part of a mental health-focused MDT. The project will contribute to learning on integrating non-law enforcement first responders into a community mental health setting. Research has not been conducted on the mental and behavioral health impacts of first responder interventions outside of a law enforcement context, however, the process of engaging relevant professionals in the management of consumers has been shown to have positive impacts on health and behavior outcomes. For some consumers who have frequent or significant contacts with first responders, this project holds the potential for significant quality of encounter improvement, decreases in hospital admissions and arrests, and improved mental health outcomes. Additionally, information gained from having first responders on consumer's MDTs will aid in the continuous quality improvement process by adding a fresh perspective to the teams. Finally, engaging County first responders in a consumer-driven care management system will facilitate their professional growth and expand their knowledge, skills, and abilities.

Evaluation Plan

During INN program implementation, HHSA will conduct a concurrent evaluation process, beginning with a design utilizing information from initial implementation to concretize process and outcome measures. Planning and implementation of the evaluation will be informed through a continuous quality improvement process, including incorporation of feedback from first responders, providers, consumers, and consumers' loved ones. Evaluation activities will be grounded in MHSA values by ensuring data collection tools and stakeholder engagement activities are conducted in a culturally appropriate manner.

Key Learning Questions

- Does utilizing the FRI lead to decreased hospital admissions and arrests related to first response situations?
- Does utilizing the FRI lead to increased non-hospital service access and utilization following a first response situation?
- How will implementation of the FRI increase the wellness and recovery of participating consumers?
- How does FRI implementation contribute to improved collaboration 1) between providers and 2) between consumers and their providers?

The County will measure program success using both process and outcome indicators. Process indicators measure to what extent the program was implemented as intended, while outcome measures will provide information on the effect of the program on consumers, community, and the mental health system overall. Evaluators will work to identify data points and evaluation methods to measure program implementation and impact. Data points may include baseline and ongoing individual-level consumer data from wellness surveys, service utilization records, hospitalization and ED records, and incarceration records; these data will be obtained from HHSA, Sheriff's Office records, hospitalization records, and other data sources as identified during the evaluation design. Quantitative data will be collected regularly to assess program progress and outcomes. Qualitative evaluation activities, including focus groups and key informant interviews, will be conducted annually.

The First Responders Initiative INN Project will employ a pre/post mixed-methods study design to evaluate changes in program-level outcome measures related to the MDT and MHUC, as well as individual-level outcome measures among consumers. Evaluation methods will be administered before and after implementation activities. The target population demographics will be analyzed to assess characteristics of consumers. In addition, the evaluation team will analyze process measure data to characterize and report on implementation activities. Data management and analysis methods will be determined based on quality and quantity of data collected.

Evaluation activities will aim to address the key learning questions of the project. The following table outlines the data to be collected (i.e., process measures and outcome measures) and potential data sources listed by their respective key learning question (Table 1).

Table 1. First Responders Initiative INN Project Evaluation Questions and Outcomes

Key Learning Question	Potential Process Measures	Potential Outcome Measures	Potential Data Source(s)
1. Does utilizing the FRI lead to decreased hospital admissions and arrests related to first response situations?	• MDT participation • # of hospital admissions • # of arrests • # of mental health urgent care visits	• # of closed encounters without removal from the community • # of closed encounters with transport to the mental health urgent care • # of closed encounters with hospital or arrest outcome • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA utilization data • Sheriff's Office incarceration records • Hospitalization and ED records
2. Does utilizing the FRI lead to increased non-hospital service access and utilization following a first response situation?	• # of non-hospital services referred during FR encounter • # of referred services utilized following FR encounter • # of non-hospital services referred at MHUC • # of referred services utilized following MHUC	• Service receipt by FRI users following encounter • Perceptions of service quality and relevance	• FRI usage data • FRI referral data • HHSA service utilization data
3. How will implementation of the FRI increase the wellness and recovery of participating consumers?	• # of hospital admissions • # of arrests • # of mental health urgent care visits • # of consumers participating in follow-up MH services • # consumers with WRAP	• Consumer experience of care • Consumer perceptions of wellness/recovery	• FRI usage data • FRI referral data • HHSA utilization data • Consumer survey • Consumer focus groups
4. How does FRI implementation contribute to improved collaboration 1) between providers, and 2) between	• # of MDT meetings attended by non-LE first responder members • # of MDT meetings integrating non-LE first responders	• Awareness of appropriate services for non-LE first responders • Increased stakeholder perceptions of system-wide collaboration	• FRI usage data • FRI tool data • Collaboration survey • Focus groups/interviews

consumers and their providers?		• Consumer perception of collaboration with first responders	with MDFT members • Focus Groups with consumers, families, and staff

The County will measure program success by engaging stakeholders to design and implement an evaluation of the FRI in a collaborative evaluation. Stakeholders will be asked to provide feedback on their experiences, and modifications to the process will be made as necessary to respond to the expressed needs. Stakeholders may include individuals from a wide variety of affiliations and demographics, including homeless, LGBTQ, Latino, youth, transition-aged youth, older adults, consumers, consumers' family members, peer support workers, county staff, and mental health providers. Stakeholders will be recruited using a similar outreach approach employed in the MHSA Community Program Planning process.

Findings from evaluation activities will be reported to HHSA, partners, and stakeholders through interim reports. Interim reports will provide updates on program progress through process measures. Upon completion of the Innovation project, findings from overall evaluation activities, including pre/post data analysis, will be summarized in a final report to HHSA, partners, and stakeholders. The final report will summarize findings related to program process, program outcomes, collaboration partners, impact on overall mental health system, and resources (e.g., funding, staff) invested in the Innovation project. The final report will also serve as a documentation of the innovative practices implemented in the Innovation project, which can serve as a model for other counties in California to implement the approach within their jurisdiction. Successful outcomes from the project would support broader implementation of an FRI model in community mental health settings with consumers who utilize emergency response services in the context of their mental health needs.

Contracting

Yolo County HHSA will utilize data from evaluation activities and stakeholder engagement activities to ensure continuous quality improvement throughout the project period. Yolo County will apply MHSA INN funds to support contracts to fulfill key roles and functions, as needed. Yolo County will keep contract partners informed of regulatory compliance policies relevant to the project.

Additional Information for Regulatory Requirements

Certifications

Certifications and assurance of compliance with MHSA Innovative Project regulatory requirements are documented in the Yolo County Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020*.

Community Program Planning

Yolo County conducted a Community Program Planning (CPP) process for its Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan 2017 – 2020* between September 2016 and February 2017. During the MHSA CPP, stakeholders identified the gap between first response services and mental health services as well as the need to integrate non-law enforcement first responders into MDT teams. Stakeholders highlighted the need to improve support for consumers who frequently interact with first responders due to mental health crises. Thus, community input from the MHSA CPP process informed the development of the First Responders Initiative Innovation Project.

The community program planning team was led by Karen Larsen, Department of Health and Human Services Director; Sandra Sigrist, Adult & Aging Branch Director; Joan Beesley, MHSA Coordinator; and Resource Development Associates (RDA), a consulting firm with mental health planning expertise. In order to ensure the planning process reached a broad spectrum of stakeholders, the planning team employed the following outreach efforts: flyers, email distribution lists, phone calls, and announcements for the MHSA planning summit. Materials were made available in Spanish, when applicable. Stakeholders included individuals from multiple communities, including homeless, LGBTQ, transitional age youth, youth, older adults, consumers, consumers' family members, peer support workers, county staff, Latino, and mental health providers. In addition, stakeholder input was gathered from individuals with a wide spectrum of affiliations including: government agency, community-based provider, law enforcement agency, education agency, social services agency, veterans organizations, and medical or health care organization. Furthermore, efforts were made to include participants throughout the County, including CPP activities and events held at different locations throughout the County and at different times of day to promote opportunities for participation.

The CPP incorporated a participatory framework to encourage buy-in and involvement from stakeholders including service providers, consumers, family members, other professionals likely to have contact with people with mental health needs, and interested community members. Throughout the planning process, the planning team made presentations to the Yolo County Local Mental Health Board (LMHB) and Board of Supervisors (BOS), both of which reviewed and helped to refine the recommendations made by the MHSA planning team. All meetings of the LMHB and BOS are open to the public. All participants in the planning process were provided with feedback forms and comment boxes for RDA staff to use a guiding and input tool throughout the process. All forms were anonymous to protect participant privacy and confidentiality.

Yolo County's MHSA CPP was built upon the meaningful involvement and participation of mental health consumers, family members, county staff, providers, and many other stakeholders. The planning team carried out a set of community meetings and information-gathering activities to engage stakeholders in all stages of the planning and strategy development process in order to ensure that the planned activities reflected stakeholders' experiences and suggestions.

The MHSA CPP was comprised of a variety of meetings and activities, as described in Table 2.

Table 2. Community Program Planning Process

Activity	Purpose
Community Meetings	
Kickoff Meetings (Local Mental Health Board, Board of Supervisors, MHSA Stakeholders)	The Kickoff Meetings provided information about the proposed planning process timeline, and to gather feedback about what was missing or suggestions to improve the proposed process.
Board and Committee Meetings	
Local Mental Health Board	Members of the Local Mental Health Board calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Community Corrections Partnership	Members of the Community Corrections Partnership calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Board of Supervisors	Members of the Board of Supervisors calendared CPP activities to discuss and provide feedback on MHSA planning processes, progress, and input.
Needs Assessment	
Focus Groups	The focus groups gathered input from providers and community members about their experiences with the mental health system and their recommendations for improvement.
Leadership Interviews	The Leadership Interviews facilitated understanding of the types and levels of services in each system of care across MHSA components, access points into each system, referral pathways, and touch points with services outside of the mental health system.
Stakeholder Surveys	The Stakeholder Surveys collected information from a wider audience beyond the focus groups, including the Russian community, consumers and families, and parents with minor children.
Quantitative Data Analysis	HHSA provided data regarding services supported by MHSA funds. Quantitative data analysis was conducted to characterize the number and profile of persons served as well as outcomes.
Strategy Development	
System of Care and Component (i.e., Child/TAY, Adult/OA, CFTN, WET, INN) Summits	The System of Care Summits built on from the Leadership Interviews and Focus Group information to identify key mental health service needs, unserved and underserved populations and geographic areas, barriers to entry and ongoing access of mental health services, workforce shortages, and needs related to capital facilities and technology.
Community Report Back Meetings	The Community Report Back Meetings presented the results of the system of care summits to stakeholders.
Board of Supervisors Meeting	Members of the Board of Supervisors calendared CPP activities to discuss stakeholder feedback, strategic planning, and MHSA plan development.

Public Review Process	
30-Day Review Period (February 17, 2017 – March 20, 2017)	The 30-Day Review period allowed for a draft plan to be distributed to the Board of Supervisors, Local Mental Health Board, county staff, service providers, consumers and family members, and those whose email addresses are associated with the stakeholder listserv. A public notice was also submitted and published through The Davis Enterprise and The Woodland Daily Democrat newspapers, county website, paper copies at HHSA department headquarters in Woodland and other sites throughout Yolo County
Public Hearing (March 22, 2017)	Stakeholders were engaged to provide feedback about the Yolo County MHSA *Three-Year Program and Expenditure Plan 2017 – 2020* . Four stakeholders attended the public hearing, representing county staff, the local mental health board, and consumers and family members. The full MHSA plan document, which summarizes public comment, is available at: http://www.yolocounty.org/health-human-services/agency-information/mental-health-services-act-mhsa

CPP participants were trained on the specific purposes and MHSA INN projects during the MHSA Component Planning Summit, which followed the system of care and component planning summits and addressed WET, CFTN, and INN. In response to the recent regulatory changes to the PEI and INN components, RDA staff reviewed program alignment with the new MHSA regulations and discussed options to bring services into alignment with these. During this summit, RDA reviewed findings from the needs assessment in each of these areas as well as findings and recommendations that emerged from the two system of care planning summits. The component work session resulted in a set of consolidated ideas, programs, and recommendations for HHSA have considered in the feasibility analysis.

Primary Purpose

The primary purpose of the First Responders Initiative (FRI) Innovation Project is: 1) to improve collaboration between non-law enforcement first responders, other service providers, and consumers via the MDT modification, and 2) to increase the quality of mental health services (including measurable outcomes) via the MDT modification and the MHUC. Both components of the FRI aim to improve outcomes for individuals who have repeated, regular contact with first responders and who typically present with a mental health crisis that is too severe to remain where they are but not critical enough for a psychiatric hold.

MHSA Innovative Project Category

The Yolo County MHSA Innovation First Responders Initiative makes a change to the MDT model, an existing mental health practice with an empirical base. The modification is unique and has not been implemented in other jurisdictions, so has not yet been demonstrated to be effective. Together, the MDFT and MHURC center are expected to 1) improve collaboration between mental health and first responder agencies through the MDFT process, and 2) improve consumer outcomes through a decrease in

incarcerations, hospitalizations, and ED visits and increase in service connectedness, consumer recovery, and collaboration between staff as well as between staff and consumers.

Target Population

The First Responders Initiative will focus on individuals throughout Yolo County who have repeated, regular contact with first responders, including at EDs and in the community, but whose need is too acute to remain where they are and not acute enough for a psychiatric hold. Yolo County estimates that law enforcement alone respond to over 4,000 mental health related calls annually. In 2016, the Davis, West Sacramento, Winters, and Woodland Police Departments and the County Sheriff had 4,081 calls for service related to mental health. While likely an underestimate, this establishes a baseline for how many interactions local law enforcement agencies may have with persons experiencing mental health problems. This estimate does not include police calls that were not initially reported as mental health-related requests for service or people who went directly to an ED.

Target population demographic information may vary in age, gender identity, race, ethnicity, sexual orientation, and language, but is expected to reflect the demographics of all MHSA adult (18 years or older) consumers.

MHSA General Standards

This project is consistent with the following MHSA general standards set forth in Title 9 California Code of Regulations, Section 3320:

- **Community Collaboration**. This project contributes to increased engagement of County first responders into the behavioral health community structure, thus improving communication across providers and emergency care services.
- **Cultural Competence**. The varied demographic characteristics of County behavioral health consumers contribute to the need for culturally appropriate services and supports for these populations. This INN project will increase consumers and their families' ability to access relevant services by improving first responders' understanding of consumer needs and providing a recovery based location for crisis intervention that police as well as consumers and families can access in advance of or during a mental health crisis not requiring 5150 intervention.
- **Client-Driven:** This project will gather input from consumers participating in project-related services. Information regarding consumers' experiences and perceptions, gathered through evaluation activities, will inform program planning, procedures, and evaluation strategies.
- **Family-Driven:** The First Responders Initiative fosters family support and involvement at the Mental Health Urgent Care, where families will be integrated into the consumer's process as well as be able to bring consumers there before it escalates to requiring involuntary hold (i.e., 5150).
- **Wellness, Recovery, and Resiliency-focused**. The proposed INN program focuses on wellness and recovery as it encourages first responders to take an active role in consumer case planning, expanding their understanding of mental health and feeding back their unique perspective as first

responders into the MDT. The FRI allows the first responder to engage in wellness and recovery goals as a member of the MDT, and provides access to the resources and services that are necessary to reach those goals. It also provides the mental health urgent care as a community-based option for supporting consumers in recovering from crisis without the need for hospitalization.

- **Integrated Service Experience for Clients and Families**. The project supports the capacity of providers to engage with each other collaboratively to provide the services necessary to address consumer needs. FRI increases information sharing to the network of individuals important to the consumer's recovery to integrate input from first responders when appropriate.

Continuity of Care for Individuals with Serious Mental Illness

The FRI directly serves individuals with Serious Mental Illness. It seeks to provide increased and improved collaboration between professionals and to provide consumers with a new direct service, the Mental Health Urgent Care, to serve those at risk of a psychiatric hold who do not meet the criteria for a psychiatric hold. In addition, the MDFT and MHUC will increase service connectedness for consumers by bridging the gap between crisis intervention and follow up services. Increased connection to services will support continuity of care for individuals with serious mental illness. If the project proves to be successful based on measurable outcomes, the County will ensure continuity for consumers after the conclusion of the INN project by funding the continuation of the services under another MHSA component, with Medi-Cal billing, or Realignment funds as appropriate.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

In order to ensure cultural competence and meaningful stakeholder participation in the planning activities and evaluation activities, the First Responders Initiative Project will rely on a steering committee formed by those stakeholders who participated in the planning and design of this initiative or will participate in the implementation of the INN plan. Stakeholders may include county staff, providers, other professionals (i.e. law enforcement, fire, EMS, EDs), consumers, and consumers' families. The steering committee will serve as the body that enacts and monitors the continuous quality improvement efforts for the project. Evaluation findings will be communicated to stakeholders, and stakeholders will have the opportunity to contribute to interpretation reporting as well as inform any plan modifications. HHSA will also provide training and technical assistance to the steering committee throughout the project to support meaningful stakeholder participation.

Targeted actions will be made to ensure that consumers are represented in all phases of the planning process and evaluation activities. Yolo HHSA and provider staff will reach out to linguistically isolated communities, particularly for Yolo County's large Latino/Hispanic and Russian populations. Interpreters will be available at community meetings and flyers related to stakeholder engagement will be made available in Spanish and Russian. In addition, HHSA staff will reach out to the homeless and LGBTQ

communities to identify potential participants to represent their respective communities' perspectives. Evaluation tools and planning tools will be vetted with minority groups represented in the target population or stakeholder group. Furthermore, planning activities and evaluation activities will request participants to complete an anonymous demographic form, which will gather information about participants' age, sexual orientation, gender identity, race/ethnicity, residency (e.g., urban or rural), and whether they identified as a consumer, family member, or service provider. Disparities revealed through evaluation findings will be addressed by modifying planning activities to increase meaningful stakeholder involvement across diverse populations.

Deciding Whether and How to Continue the Project Without INN Funds

If effectiveness for the FRI is established via the CQI process, the County will explore funding options, including Medi-Cal and CSS funds, for continuing the project. If the FRI is not shown to be an effective program, the consumers who utilize it will be referred to other local services as appropriate for their needs. As part of the learning component of this project, Yolo County will explore if mental health urgent care can be billed to Medi-Cal under crisis intervention.

Communication and Dissemination Plan

Updates, communication, and information around the FRI will be disseminated through an initial outreach and education process so that the broad stakeholder community is aware of this initiative and how to access services, including the MHSA distribution list maintained by the County, as well as MHSA Annual Updates that follow the procedures and requirements for the CPP, approval, and dissemination. Additionally, Yolo County will post all information about FRI on the MHSA website, including information about how to access mental health urgent care services and evaluation reports. Keywords or phrases for searching for the project:

- Multidisciplinary Team/MDT/MDFT Yolo County
- Mental Health First Responders Yolo County
- Mental Health Urgent Care Yolo County
- Mental Health Crisis Yolo County

Timeline

The total duration for the project is three years, and Yolo County anticipates full operation for the pilot phase within six months of MHOAC approval. The following timeline provides a breakdown of planned activities for the first six months of the project (Table 3).

Table 3. First Responders Initiative Project Timeline for First Six Months, July 2017 – Feb 2018

	Project Month							
	2017						2018	
Milestone/Deliverable	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
MHSA ACTIVITIES FOR ALL INN PROJECTS								
MHOAC approval	■							
Quarterly Continuous Quality Improvement Activities				■			■	
INN Annual Report							■	
MENTAL HEALTH URGENT CARE (MHUC) CENTER								
Hire or reassign HHSA staff for MHUC		■	■					
Identify building space or co-locate with Navigation Centers		■	■					
Procure external evaluation services		■	■					
Design program			■	■				
Establish policies, procedures, and parameters			■	■				
Obtain permits and licensing (e.g., CUP, Medi-Cal Certification)				■	■			
Purchasing for building remodeling, office furniture, supplies, etc.					■	■		
Onboard and train staff						■	■	
Community outreach to raise awareness of program							■	
Pilot MHUC (ongoing for 30 months)							■	■
FORENSIC MULTIDISCIPLINARY TEAM (MDFT)								
Identify and Recruit MDFT members		■						
Establish working guidelines, policies, and procedures.		■	■					
Form MDFT membership			■					
MDFT Kickoff Meeting				■				
Training and technical assistance to MDFT					■	■		
Pilot MDFT (ongoing for 30 months)							■	■

The following timeline provides an overview of planned activities throughout the three years of the project (Table 4).

Table 4. First Responders Initiative Project Timeline, July 2017 – June 2020

Milestone/Deliverable	Year 1				Year 2				Year 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MHUC Project Launch (6 months)												
MHUC Pilot Implementation (30 months)												
MDFT Project Launch (6 months)												
MDFT Pilot Implementation (30 months)												
Quarterly Continuous Quality Improvement Activities												
INN Annual Report												

Project Budget

INN Project Budget and Source of Expenditures

A. Budget Narrative:
Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Budget Narrative:

Section B.

1. $790,630 per year represents salary and benefits for 4.0 FTE Clinicians, 3.0 FTE Case Managers and 0.25 FTE Analyst.
2. N/A
3. $75,000 in FY 17-18, $75,075 in FY 18-19 and $75,064 in FY 19-20 represents administrative costs at 15%.
4. Total
5. N/A
6. N/A
7. N/A
8. N/A
9. N/A
10. N/A
11. Annual cost of $520,000 represents $500,000 in contracts with local hospitals for 4.0 FTE Nurse Practitioners and $20,000 in consultant fees for program evaluation.
12. N/A
13. Total
14. N/A
15. N/A
16. N/A

Section C.

Part A.

A.1 $75,000 in FY 17-18, $75,075 in FY 18-19 and $75,064 in FY 19-20 represents administrative costs at 15%.

A.2 N/A

A.3 N/A

A.4 N/A

A.5 N/A

A.6 N/A Total

Part B.

B.1 $20,000 annually is estimated for consultant fees for program evaluation.

B.2 N/A

B.3 N/A

B.4 N/A

B.5 N/A

B.6 Total

Part C.

C.1 Total MHSA INN funds for FY 17-18 is estimated at $575,000; total MHSA INN funds for FY 18-19 is estimated at $575,075; total MHSA INN funds for FY 19-20 estimated at $575,064.

C.2 Anticipated Federal Financial Participation is estimated at $300,630 per year.

C.3 N/A

C.4 N/A

C.5 Other funding is estimated at $500,000 per year in Maddy Emergency Medical Services (Maddy EMS) funds ($1,500,000 total over three years) and $10,000 per year in Mental Health Medi-Cal Administrative Activities (MAA) billing ($30,000 total over three years).

C.6 Total

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xx	FY xxxx	**Total**
1.	Salaries	**790,630**	**790,630**	**790,630**			**2,371,890**
2.	Direct Costs						
3.	Indirect Costs	**75,000**	**75,075**	**75,064**			**225,139**
4.	Total Personnel Costs	**865,630**	**865,705**	**865,694**			**2,597,029**
OPERATING COSTs		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						

NON RECURRING COSTS (equipment, technology)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
11.	Direct Costs	**520,000**	**520,000**	**520,000**			**1,560,000**
12.	Indirect Costs						
13.	Total Consultant Costs	**520,000**	**520,000**	**520,000**			**1,560,000**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
14.						
15.						
16. Total Other expenditures						

BUDGET TOTALS						
Personnel (line 1)	**790,630**	**790,630**	**790,630**			**2,371,890**
Direct Costs (add lines 2, 5 and 11 from above)	**520,000**	**520,000**	**520,000**			**1,560,000**
Indirect Costs (add lines 3, 6 and 12 from above)	**75,000**	**75,075**	**75,064**			**225,139**
Non-recurring costs (line 10)						
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET	**1,385,630**	**1,385,705**	**1,385,694**			**4,157,029**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

Expenditures By Funding Source and FISCAL YEAR (FY)							
Administration:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	75,000	75,075	75,064			225,514
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**75,000**	**75,075**	**75,064**			**225,514**
Evaluation:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	20,000	20,000	20,000			60,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**20,000**	**20,000**	**20,000**			**60,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 17-18**	**FY 18-19**	**FY 19-20**	FY xxxx	FY xxxx	**Total**
1.	Innovative MHSA Funds	**575,000**	**575,075**	**575,064**			**1,725,139**
2.	Federal Financial Participation	**300,630**	**300,630**	**300,630**			**901,890**
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	**510,000**	**510,000**	**510,000**			**1,530,000**
6.	**Total Proposed Expenditures**	**1,385,630**	**1,385,705**	**1,385,694**			**4,157,029**
*If "Other funding" is included, please explain.							

Local Mental Health Board
Mental Health Director's Report
June 26, 2017

Personnel – We have a new Assistant Director for HHSA. Rebecca Mellot joined us on June 12th. She comes to us with over a decade of experience in integrated HHSA, in Placer and Shasta County. She is a wealth of information and we are excited to have her on our team. On July 24th, we will also be welcoming a new Community Health Branch Director, Mimi Hall. Mimi is coming to us from Plumas County. She has been the Director of Plumas County Public Health since 2008 and also served as their Veteran's Services Officer, Alcohol & Drug Administrator and Mental Health Director.

Psychiatrist Staffing- As reported last month, we have successfully recruited a full time Psychiatrist. Unfortunately, almost immediately, we lost a couple of our part time doctors. We have begun a variety of efforts to improve recruitment and retention including getting our HPSA score raised to 19 which allows doctors to get student loan repayment, developing a recruitment brochure, advertising with APA, raising the salary and hiring other prescribers such as Nurse Practitioners.

MHSA Housing Project- The ribbon cutting ceremony will be Tuesday, June 27th at 9am. You are all invited to participate.

MHSA 3 year plan-We have had to re-issue six of the eight MHSA RFPs due to the fact that only one vendor applied for each. Our Board of Supervisors want to make sure we have a competitive RFP process for all bids to ensure the highest quality, lowest cost providers.

Public Guardian transition- We conducted a salary survey of conservatorship officers in other counties and found that we were well below the mean in terms of pay. The BOS has approved an increase in salary range for these positions which should help us with recruitment and retention.

Proposition 47 Grant- In February 2017, staff submitted an application to the Board of State and Community Corrections for Proposition 47 grant funding. Yolo County was one of the 23 projects that the Committee is recommending for funding. Yolo's project proposes to use approximately $6 million in Proposition 47 grant funds (over a 38 month period) to expand Yolo County's existing continuum of criminal justice diversion programs. Specifically, the proposed project will provide wraparound services to individuals who are eligible for a diversion program, but are unlikely to succeed without intensive supports due to their history of mental health issues and/or substance use disorders.

Budget Update- On June 13th, the Board of Supervisors approved the County's budget for 2017-2018 fiscal year. HHSA continues to have the largest budget within the county, comprising almost 40% of revenues, expenditures and personnel. HHSA's budget was addressed specifically at the budget hearing for these reasons. The $4.5 million deficit in behavioral health was discussed in addition to the plans for the new Crisis Management services for the coming fiscal year.

Davis Site- In addition to the new wellness center at the Davis site, we are discussing a re-design of the existing mental health clinic and how to incorporate that with the wellness center re-model.

Maddy Funds- There is a set of funds associated with our EMS agency that are tied to traffic fines. One of the pots of money locally has grown substantially and is tied to filling a void in emergency departments. We have met with Dignity and Sutter and are proposing to give them each $250,000 per year for three years to hire two Nurse Practitioners that will assist at the Mental Health Urgent Care and divert emergency room usage by those in mental health crisis.

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board
Communication and Education Committee Meeting
Monday, June 26, 7:00 PM – 9:00 PM

137 N. Cottonwood, Woodland, CA 95695 – Bauer Building, Thomson Conference Room

All items on this agenda may be considered for action.

James Glica-Hernandez
Chair

Nicki King
Vice-Chair

Reed Walker
Secretary

District 1
Bret Bandley
Martha Guerrero
Sally Mandujan

District 2
Nicki King
Tom Waltz
Juliet Crites

District 3
Richard Bellows
Laurie Ferns
James Glica-Hernandez

District 4
June Forbes
Robert Schelen
Ajay Singh

District 5
Brad Anderson
Reed Walker
Vacant

Board of Supervisors Liaison
Don Saylor

Alternate
Jim Provenza

COMMITTEE MEMBERS:

James Glica-Hernandez (Chair); June Forbes, Brett Bandley, Reed Walker, Sally Mandujan, Laurie Ferns, and Ajay Singh

AGENDA:

1. Call to Order and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes
5. Announcements and Correspondence
6. Resource Guide
7. Future Alternative to the Public Forums
8. Future Meeting Planning and Adjournment

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, June 23, 2017.

_____

Iulia Bodeanu, Administrative Services Analyst
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services Agency

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board
Budget and Finance Committee Meeting
Monday, June 26, 2017, 7:00 PM – 9:00 PM

137 N. Cottonwood, Woodland, CA 95695 – Bauer Building, Thomson Conference Room

All items on this agenda may be considered for action.

COMMITTEE MEMBERS:

Richard Bellows (Chair); Bob Schelen; Nikki King;

AGENDA:

1. Call to Order and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes
5. Announcements and Correspondence
6. Budget Review
7. Discuss Budget & Finance Goals
8. Discuss Public Input
9. Future Meeting Planning and Adjournment

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, June 23, 2017.

Iulia Bodeanu, Administrative Services Analyst
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services Agency

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COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board
Program Committee Meeting
Monday, June 26, 7:00 PM – 9:00 PM

137 N. Cottonwood, Woodland, CA 95695 – Bauer Building, Thomson Conference Room

All items on this agenda may be considered for action.

COMMITTEE MEMBERS:

Martha Guerrero (Chair); Thomas Waltz; Brett Bandley; Reed Walker

AGENDA:

1. Call to Order and Introductions
2. Public Comment
3. Approval of Agenda
4. Announcements and Correspondence
5. Data Notebook
6. Future Meeting Planning and Adjournment

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before June 23, 2017.

Iulia Bodeanu, Administrative Services Analyst
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services Agency

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Yolo County Local Mental Health Board
Long Range Planning Calendar

Meeting	Agenda Item	Agency/Presenter	Type	Timing
1/23/17	Final Strategic Plan Presentation	Ad Hoc Committee: June Forbes, Tawny Yambrovich, Richard Bellows and Bob Schelen	Presentation	Past
1/23/17	LMHB Trainings	Richard Bellows	Presentation	Past
2/27/17	LMHB Trainings Proposal	Richard Bellows	Motion/Approval	Past
2/27/17	Board Name Change Discussion and Vote	Ad Hoc Committee: Nicki King, Bret Bandley, Martha Guerrero, Bob Schelen, and Ajay Singh	Recommendation	Past
2/27/17	Yolo County 2016 Data Notebook Review and Approval	Ad Hoc Committee: James Glica-Hernandez, Sally Mandujan, Nicki King, and Brad Anderson	Motion/Approval	Past
3/27/17	Approval of Strategic Plan	Ad Hoc Committee: June Forbes, Richard Bellows and Bob Schelen	Motion/Approval	Past
3/27/17	MSHA Three-Year Program and Expenditure Plan FYs 2017-2020 for Local Mental Health Boards recommendation	Joan Beesley, MHSA Manager	Presentation	Past
3/27/17	Committee Workshop	All	Committee Meeting	Past
4/24/17	Annual Report Approval	Executive Committee	Recommendation	Past
4/24/17	Behavioral Health Services Budget Presentation	Connie Cessna-Smith, HHSA Fiscal Administrative Officer	Presentation	Past
4/24/17	Public Forum	CEC	Public Forum	Past
5/22/17	2018 LMHB Meeting Calendar Location Discussion	Richard Bellows	Discussion	Past
5/22/17	Conservatorship Presentation	Laurie Haas, HHSA Chief Deputy Public Guardian	Presentation	Past
5/22/17	Annual Election of Officers	All	Adoption	Past
6/26/17	MHSA Update/RDA	RDA	Presentation	Planned
6/26/17	Public Forum	CEC	Public Forum	Planned
6/26/17	Committee Workshop	All	Committee Meeting	Planned

Last Updated 6/23/17

6/26/17	Community Intervention Training (CIT)	Mike Summers	Presentation	Planned
8/28/17	Approval of LMHB Recommendation on the BHS Recommended Budget	All	Recommendation	Planned
8/28/17	Quality Management	Samantha Fusselman, HHSA Quality Management Manager	Presentation	Planned
9/25/17	Committee Workshop	All	Committee Meeting	Planned
9/25/17	Mental Health Services Presentation	TBD	Presentation	Planned
9/25/17	Board Training on Oct. 21 in Sacramento	Susan Wilson	Training	Planned
10/23/17	TBD			
12/4/17	2018 LMHB Meeting Calendar Approval	All	Adoption	Planned
Suggestions				
TBD	YCCC Presentation			
TBD	Rose King, Mental Health Activist			
TBD	CSOC overview including contracted services (CCHC, YFSA, TPCP)			
TBD	AOT Update (TPCP)			
TBD	Public Guardian Updates/ HHSA Department Updates			