To: Local Mental Health Board Members
Karen Larsen, Director, Yolo County Health and Human Services Agency

From: Nicki King, Chair, Local Mental Health Board
Jonathan Raven, Vice Chair, Local Mental Health Board

Date: October 18, 2021

RE: Opportunities to Improve 2021-22 Yolo County MHSA Evaluation Report

This memo proposes opportunities to improve the clarity and effectiveness of the Yolo County MHSA Evaluation Report. We recommend the Yolo County Health and Human Services Agency (HHSA) implement the recommendations in the memo for the 2021-22 Yolo County MHSA Evaluation Report and release a second draft to the Local Mental Health Board to assist with the community's effort to evaluate new projects and advise the Agency on funding for existing programs. In an effort to streamline the comment process, we coordinated with NAMI Yolo County leadership to draft these recommendations. The NAMI Yolo County Board of Directors will consider support for these recommendations at their October 28th meeting and also submitted separate questions regarding the Evaluation Report to HHSA.

Opportunities to Improve 2021-22 Yolo County MHSA Evaluation Report

The 2021-22 Yolo County MHSA Evaluation Report is an excellent tool to communicate the benefits of MHSA expenditures to the community and the Yolo County Board of Supervisors. While not required by the MHSA, it provides information essential to evaluate whether existing programs are benefiting people living with serious mental illness, including intervention and prevention. We agree with the Health and Human Services Agency characterization in the executive summary of the Evaluation Report that the performance evaluation process is incomplete.[1] Much more work is needed to determine whether the 22 programs allocated a total of $18.9 million in 2020-21 ($12.9 million was spent) accomplished their intended goals. We believe the report could turn into a model for other counties, as well as a roadmap to needed adjustments and changes in our own delivery of service if the County continues to improve data collection for each program and the recommendations suggested in this report are implemented.

<u>Overview of Report Omissions</u>

While the Evaluation Report provides some useful information to guide conversations about program efficacy, additional information is needed. Of the 22 programs described in the report,

[1]. We wanted to recognize the honesty of HHSA in introducing the report with the following sentence on page 6 of the Executive Summary, "HHSA acknowledges the data is incomplete; ongoing progress is being made to strengthen the overall evaluation and reporting on MHSA programs impact…HHSA acknowledges these evaluation efforts are a work in progress represent one step in a multiphase approach to continuous evaluation of the county MHSA programs focused on accountability and quality improvement.."

none of the programs list the performance measures for the three Results-Based Accountability questions:

1) How much of our original goals did we accomplish? ~~did we do?~~
2) How well did we do it?
3) Is anyone better off? If so, who, and are there any equity implications for this assessment of outcomes?

We recognize HHSA is in the process of updating its contracting processes to ensure all contractors and internal divisions provide this information but wanted to document the need to provide the information in case this information is available to include in the report. See Attachment A for NAMI Yolo County's example of the type of information listed for these questions in a contract and which is available to include in the report. In addition, no baseline information is provided about the services the County or contractor expected to provide to compare to the services the County or contractor actually provided. For 15 of the 22 programs (68%) no or limited data is provided in the Evaluation Report, as shown below. We recognize that many of these programs are delayed by COVID-19, but the Evaluation Report does not provide information as to why no data is provided for these programs.

Limited Data

- Children's Mental Health Services
- Pathways to Independence
- Adult Wellness Services
- Older Adult Outreach and Assessment Program

No Data

- Tele-Mental Health Services
- Cultural Competence
- Youth Early Intervention First Episode Psychosis Program
- Maternal Mental Health Access Hub
- K-12 School Partnerships Program
- College Partnerships
- Crisis Now Learning Collaborative
- Mental Health Career Pathways
- Mental Health Professional Development
- Central Regional WET Partnership
- Peer Workforce Development Workgroup
- Race and Ethnicity data (should be collected where possible, and explanations of why such data could not be collected for each program should be provided

In some cases, no data is reported but the MHSA Finance Update shows expenses in the 2020-21 fiscal year. Tele-Mental Health Services (non-FSP) spent $265,640 in 2020-21, for example. For the programs that do have data, the Health and Human Services Agency does not appear to present information about services that were not provided but are listed in the contract as a

deliverable. NAMI Yolo County, for example, did not provide any peer-to-peer education classes in 2020-21, but that information is not included in the evaluation report of peer-and family-led services on page 20. For some important programs, such as the $800,000/year in funding provided to support services at Pine Tree Gardens East and West, two adult residential facilities for 28 adults living with a serious mental illness, there is no mention of the program in the Evaluation Report.

Opportunities for Improvements

The Health and Human Services Agency could implement the following improvements to create a model evaluation report for use by the community, HHSA staff, the Local Mental Health Board, and the Board of Supervisors.

1. **Describe whether HHSA staff members, a contractor, or both are providing the services and identify how many staff in each category and the approximate number of total hours.** The description of the program in the report does not describe whether the Health and Human Services Agency delivered the program, a contractor delivered the program, or both. In the case of Peer and Family-Led Support Services on page 20, for example, NAMI Yolo County provides 100% of the services for this program and all data represents NAMI Yolo County's work.
2. **Provide the name of the contractor (if applicable), the amount of the contract, the amount spent, and the cost/individual served.** HHSA provided this information in a separate document entitled MHSA Finance Update, which requires the reader to flip back and forth between the Evaluation Report and the Finance Update. HHSA should include this information in the Evaluation Report to make it easy for stakeholders to understand the status of expenditures under the program. NAMI Yolo County, for example, signed a contract for $100,000 last year to provide Peer and Family-Led Support Services last year, but spent less than $70,000 of the contract. The potential cost/individual served is provided as an estimate for 2021-22, but no information from 2020-21 is provided in the report although the Health and Human Services Agency has this data.
3. **Provide an overview of the program in the evaluation report, including the program's connection to eligible MHSA activities, and deliverables for the fiscal year.** For each program, HHSA should provide information about the program to complement the goals and objectives, as well as provide information tying the program to eligible MHSA activities. Without this information, it's impossible to measure the program's performance against HHSA's expectation for the program in that fiscal year. We also need to know how many of those performance goals were even partially met during FY21? We think there are things we could be learning about the appropriateness of our objectives and how long it will take to reach them.
4. NAMI Yolo County suggested including deliverables in their 2021-22 HHSA contract and is willing to provide such information as an example. Each program should develop deliverables at the start of the fiscal year and report on progress as part of the Results-Based Accountability process at the end of the fiscal year.
5. **Provide the Results-Based Accountability measures included in the contract and or/developed for staff at the Health and Human Services Agency in the evaluation**

report, as well as the relevant associated data. For NAMI Yolo County, for example, this information is provided in Attachment A and would provide an overview of what NAMI Yolo County did and did not accomplish during the fiscal year.

6. **Add explanations for programs with no or limited data.** For each of the programs for which there is limited or no data, the Evaluation Report could explain why and efforts underway to move the programs forward and expend money allocated to that program in the three-year plan. The County may also recommend reallocating some of these funds to another program or a new program.
7. **Include information about important expenditures that are part of a larger program.** The Evaluation Report should describe major expenditures like the operation of Pine Tree Garden East and West and collect data to measure performance consistent with the contracts. The contract between North Valley Behavioral Health (the operator of the Pine Tree Gardens homes) and Yolo County contains RBAs, for example

ATTACHMENT A: NAMI YOLO COUNTY EXAMPLE

(Shared by Petrea Marchand, President of Nami-Yolo)

NAMI Yolo County contracted with the Health and Human Services Agency for $100,000 to provide peer- and family-led support services. NAMI Yolo County's 2020-21 contract has the following Results-Based Accountability performance measures:

PM1: How much did we do?

Staff – NAMI volunteers and peer and family led workers

Customers - # of Peer-to-Peer educational classes offered, # of Family classes offered, # of participants who received NAMI support

PM2: How well did we do it?

2.1. # of attendees for Peer to Peer educational classes

2.2. # of attendees for Family educational classes

2.3. # of attendees for In Our Own Voice presentations

2.4. # of participants served by NAMI supports

PM3: Is anyone better off?

Stigma Reduction

3.1 % of participants of Peer-to-Peer education classes that report an increase in the management of stress symptoms

3.2. % of participants of Family Educational classes that reported an increased understanding of mental health symptoms

3.3 % of community members reporting an increase in understanding mental health symptoms and how to recognize after participating in an In Our Own Voice presentation

Increased Knowledge of Mental Health Symptoms

3.4 % of participants of Peer-to-Peer education classes reporting an increase in the ability to recognize the signs and symptoms of mental illness

3.5 % of participants of Family education classes reporting an increase in knowledge of mental health symptoms

3.6 % of community members reporting an increase in knowledge of mental health symptoms after participating in an In Our Own Voice presentation

Increase Access to Mental Health Services

3.7 % of participants of Peer to Peer educational classes reporting an increased ability to access community resources/services

3.8 % of participants receiving NAMI supports who report an increased ability to access community resources/services

Increase Support for Family Members

3.9 % of participants of Family education classes reporting increased support

NAMI Yolo County

National Alliance on Mental Illness

NAMI Yolo County Executive Committee Questions on
Yolo County MHSA Evaluation Report
October 20, 2021

1. Why doesn't the Evaluation Report include the Results-Based Accountability metrics from each contract and for each Health and Human Services Agency program?
2. Why doesn't the Evaluation Report include information about the work or contract deliverables, as well as information about work contractors or the County did not accomplish in a given year (e.g. because of COVID-19 or other reasons)? This information helps with program evaluation.
3. On page 18 for Community-Based Drop-In Navigation Center, why were only 30% of clients successfully linked with psychiatry? Why only 70% to specialty mental health? What can be done to improve these percentages?
4. On the Community-Based Drop-In Navigation Center summary (p. 19), the accomplishments mention helping people experiencing homelessness to move to more permanent housing and access services but does not mention that these people are living with a mental illness per the MHSA requirements. Was this program focused on helping adults living with serious mental illness?
5. On page 28 for the Early Childhood Mental Health Access and Linkage Program, is it possible to provide improved descriptions of the work this program is doing related to prevention, defined as "reduce risk of developing a potential Serious Mental Illness and build protective factors (p. 22)" and "treatment and interventions, including relapse prevention, to address and promise recovery and related functional outcomes for a mental illness early its emergence…(p. 22)"[1]? The accomplishments section does not clearly link the purpose of the funding with the program work.
6. On page 30, what is PM BT and why did only 25% of the clients graduate?
7. On page 34 for the Rural School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? It appears from the HHSA expenditure report that this program cost $135,400 and served 132 people for a cost of $1,025/person.
8. On page 35 for the Rural School-Based Access and Linkage Program, one of the challenges is insufficient broadband internet access. Has HHSA considered requesting American Rescue Plan funding to address this issue, since broadband access in disadvantaged communities in an eligible expense of these funds?
9. On page 36 for the Urban School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? This program cost $247,128 and served 31 people in 2020-21 for a total of $7,971/person served. How

[1] On page 29, one of the program challenges is "Mental health has become a bigger need. Families with private insurance have a harder time navigating the system because Help Me Grow doesn't have a toll free number that we can give them like with Medi-Cal recipients, Mental health services for the whole family has become a big need." If the focus of this program is early intervention to address mental health issues, why is this listed as a challenge?

many people does the program expect to serve in 2021-22 and how is the program planning to improve their performance?

10. Same question as Question 9 for Rural School-Based Strengths and Mentoring Program and Urban School-Based Strengths and Mentoring Program.
11. On page 41 for the Latinx Outreach/Mental Health Promotores Program, why does it provide the estimated cost/person served for 2021-22 and not for 2020-21? The program served 84 clients in 2020-21 at a cost of $263,458 or $3,136/person served. The program is slated to receive $438,512 in 2021-22. What is the justification for this increase in funding?
12. For the Tele-Mental Health non-FSP program, which reported no data for 2020-21, why is the amount budgeted increasing from $73,390 to $1.38 million? What did the program accomplish for the $265,000 spent in 2020-21?

MHSA Evaluation Report Questions/Feedback/Suggestions
Jonathan Raven
LMHB Vice-Chair
October 11, 2021

1. One critical piece of information if the $20 million fund balance. As most people will not read the full report (e.g., most BOS members), it would be helpful to include this in the Executive Summary. You can separate into the 3 categories. Include how much is already encumbered (i.e., unspent) as well as new money (increase in tax revenue). Also include a sentence or two about the process to apply for the available funding.
2. Please include in each program report who the contractor is.
3. Have you given direction to each program about how to report the Outcome Measures using RBA? In reports from HHSA, Probation, the Sheriff, outcome measures are specifically separated into the 3 RBA questions with responses for each of them. It would be helpful to have this consistency in all program reports.
4. Most of the reports have an "Estimated Number to be served in FY 21/22" and a total served in FY 20/21. It would be helpful to see the estimated number of clients served for FY 20/21 to see if they met their goal (of course this year, COVID will have an impact on that).
5. Why is there no RBA analyses for Tele Mental Health Services (p. 15)? The data provided does not answer the latter 2 RBA questions.
6. Computer-Based Drop in Nav (p. 18) does a great job of listing accomplishments.
7. Peer and family led support (p. 20) does an outstanding job of providing information.
8. Why is there no data for Cultural Competence (p. 24)?
9. Early Childhood (p. 25) program provided an outstanding report.
10. Same with Maternal Mental Health (p. 30).
11. Why is there such limited information on Youth Early Intervention (p. 32)?
12. What is "In Process" mean for Maternal Mental Health (p. 33)?
13. K-12 School Partnership report is great (p. 34)!
14. What is the status of College Partnerships (p. 40)?
15. Latinx Outreach is great (p. 41)!
16. Senior Peer is great (p. 44)!
17. Are we unable to get any results or Innovation Data (I realize it's data)?
18. Under Yolo MHC, it would be great to see the allocation of MHSA $ to this program. Most of the program is not covered by MHSA $.
19. Yolo Assertive Community Treatment is actually formatted by RBA with the questions and responses. Can all program be formatted that way?

Submitted by Antonia Tsobanoudis

The electronic file name implies it is an Evaluation of the Year 20-21, which I think it is, but the title on the document title page says 21-22. Either make it a Fall 2021 Evaluation of FY 20/21, or Evaluation of FY 20/21 by changing the report name. Is this some kind of County nomenclature I haven't noticed before?

I don't see any contractor's names in it -- it would help me, in Board meetings especially, to know who did what, for how much, and possibly *why* they needed more or less than the original contract.

Project descriptions, goals and data, synopsis of contract execution, should all be submitted by the contractors to almost plug and play. Maybe a simple one-page form can be filled out as part of their payment quarterly or yearly, so they track what you want to put in the MHSA reports? I know there are the LOCUS, RDA, and other evaluatory important field specific surveys and goals, but I just mean having an overarching view of a Contract/Project tracking would be nice. Like easily seeing k vs actual,

Page 10: could it please add three columns for Estimated 21-22, Contracted for 20-21, and Actual for 20-21 since that's the year we're evaluating? Maybe take out the "target numbers" served" to put in another table? (i think the columns can be added in portrait view, as is, if some program names wrap text and other columns like HHSA BRanch narrow/) This is a critical and first step to better integrating the separate financial report, which could still be an addendum, in the same report and referenced.

page 10 -- thank you for highlighting which programs are still in process.

Also, I see an importance in adding another table ,same format as on page 10, highlighting the Target Number SERVED 21/22, Actual Numbers Served 20/21, and proposed increase in 3-year budget (just actual change in this table). This clearly spells out one reason to increase budgets so that in hindsight, MHSA funds will be more protected in any future critical review that could happen. It happens.

Again, in overall format of program reviews (which are great by the way! easy on the eyes, good job!) adding more evaluation of previous year in the bubble table so that there is an additional row showing, Estimated/Contracted costs for 20/21, squeeze in an ACTUAL 20/21 Costs, then actual Numbers served 20/21, and Actual Cost/person served 20/21? Again, bring in more financials info into the actual Eval Report

p 11 -- the number of estimated children under 5 to be served is going down to 90 from 110. Are the costs for this program going up, sorry it's hard (time consuming) for me not to have a stand alone document and play sleuth? Why are the numbers served going down? especially in the aftermath of covid? I hear covid produced more babies!

p 12 -- how is this program addressing high schoolers? Is there any collaboration with the school districts (list in objectives)? How or why are the numbers served jumping from 15 up to estimated 75? Why ONLY 2 FT staff for a $2.1 million project?--Ah, it's County staff, not contracted staff, listed right?

p 13 -- It is not clear that the previously contracted out FSP and the COunty's FSP are now under one contract, this change having happend in 20/21. Big change!

p 13 -- Is 200 estimated enough? That's estimating an increase of 52 adults... with PTG, potential increase in housing from ARP funds, should this increase estimated number increase and funding increase here more? I guess PTG, Paul's Place, are under other contract's? I'm not sure of that because actual contractors aren't mentioned in this report or any MHSA report -- i'd have to go digging in posted contracts.

p 13 -- I'd like to see last year's "bubble table numbers" here to compare and make it an easier read and evaluation, please.

p 13 -- in working my FSP case workers, new Telecare and old TPCP, supported housing in Yolo needs an increase! Where can the cost of many 6-bed or less (easier licensure) Board and Care go? Or another 15-bed PTG3? Where can semi-supported Room and Boards go?? Especially long-term Room and Board's for people with SUD!??? Then that homeless days will surely drop to less than half.

Under WET, this whole section can be financially beefed up. Especially the last one, on page 51, "Peer Workforce Development Workgroup" with the Peer certification coming through around May2022, it would be great to see a robust Peer role in the life of all HHSA clients, with peers trained in demonstrating life skills, professionalism, and respect of patients/clients. Group settings should not be excluded.

Submitted by Nick Birtcil

I'd still love more information about spending down that $17m