



## Mental Health Services Act (MHSA) Steering Committee Meeting

Thursday, September 2, 2021 / 3:00 – 4:30 PM

Zoom Meeting: <https://us02web.zoom.us/j/83216209789>

Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

### MINUTES

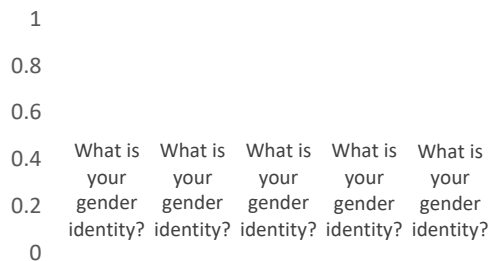
1. **Welcome** - *Jean Perry, MHSARC Commissioner & Leticia Bido, MHSARC Commissioner* 5 min
  
2. **Logistics & Agenda Review** - *Doris Estremera, MHSA Manager* 5 min
  - Introductions (name, pronouns, affiliation) were shared via chat
  - Previous meeting minutes available on the MHSA website, [www.smchealth.org/MHSA](http://www.smchealth.org/MHSA)
  - Stipends available to clients and family members participating; information collected via chat
  - Notice that meeting was being recorded
  - Participation guidelines – enter questions in chat, will address those first, can also use raise hand button during question/answer and unmute when called on, share airtime, practice both/and thinking, be brief and meaningful
  - For General Public Comments (non-agenda items) requested sign up via chat
  - Quick Poll – 12 participants reported demographics, results below:

What is your age range?	
26-59	67%
60+	33%

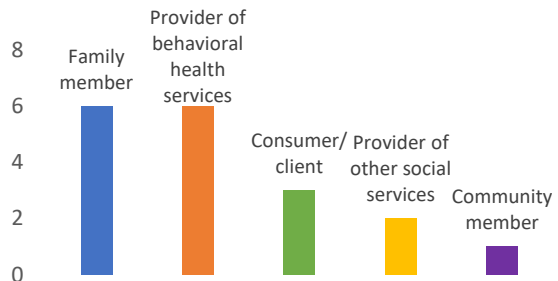
What is your gender identity?	
Female/Woman	67%
Male/Man	25%
Gender Non-Conforming	8%

What part of the county do you live in OR work in?	
Central County	50%
County-wide	25%
East Palo Alto/Belle Haven	8%
North County	17%

#### What is your race/ethnicity?



#### Stakeholder Group





- MHSa Overview
  - 1% tax imposed on personal income over \$1M to transform public mental health systems
  - 76% of revenue allocated to direct services and treatment for individuals living with serious mental illness; 51% of this must go to Full Service Partnerships (FSPs)
  - 19% goes to PEI; 5% to INN
  - Two components WET and CFTN do not have automatic allocations but, counties can allocate up to 20% per year to these components. In SMC, we transfer annually to WET

**3. General Public Comment – Leticia Bido** 10 min

- **Instructions**
  - For non-agenda items; comments limited to 2 minutes
  - Please do not respond to public comments to avoid back and forth, we will respond if we are able to or follow-up after the meeting
  - Requested names of individuals who are interested in providing general public via the chat. 10min
  - Additional public comments can also be submitted via email to [mhsa@smcgov.org](mailto:mhsa@smcgov.org).

- **Comments**
  - Pat: I am very familiar with the police and mental health clinician pilot program [crisis response] between four cities (Daly City, South San Francisco, San Mateo and Redwood City). RWC and SM have not found a clinician to join the pilot program. It is my strong belief that the reason for this is that a certified mental health clinician is not necessary. The San Mateo street mental health program staff are not certified, the Kahoots program are not certified. San Francisco hired Kahoots consultant to help develop their program, Marin County (Santa Rosa) has a similar program that is about to kick off. The Kahoots program manager testified before a senate subcommittee indicating that no Kahoots clinical person has ever been injured or killed, the program has an EMT (not an armed police officers). I wish the County would consider and change the job requirements.
    - Commissioner: thank you very much for this topic, it’s certainly something helpful to know and at the Commission we are paying close attention to this
  - Susan (Executive Director, Contractors Association of SMC): we have 23 non-profits that run mental health and substance use programs in our association, and we would gladly partner in this process. StarVista happens to be one of the organizations and we are interconnected but, have other agencies that would be able to



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support your needs. If you want to share information with me, I will share with our network. We are your experts in the County.

- Thank you for sharing your services and letting others know you are available as a resource

#### 4. MHSA Steering Committee Goals & Workgroups – Jean Perry

- **DRAFT MHSA Steering Committee Goals**
  - At the previous Steering Cmtee meeting we shared that we made a change to the MHSARC by-laws in terms of how the MHSA Steering Committee functions within the MHSARC. This gives more voice and makes it our explicit role to advise the MHSARC.
  - Proposed Goals include:
    - 1) Represents diverse community and stakeholder voices.
    - 2) Engages and supports participation of individuals living with mental health challenges, their families and their direct service providers.
    - 3) Includes equity and inclusion as an active goal of all MHSA processes and priorities.
    - 4) Develops meaningful and simplified input processes.
    - 5) Engages in funding, planning, implementation and evaluation decisions of MHSA services and programs.
    - 6) Are active participants, attending Steering Committee meetings and workgroups and other planning processes as appropriate.
  - This is a more active role than we previously had; workgroups will be subsets of the MHSA Steering Committee and include public members
  - It isn't anticipated that all MHSA Steering Committee members will be able to participate in every workgroup.
- **Workgroup Participation Guidelines**
  - In previous meeting we shared that there will be two workgroups in the course of a fiscal year (Fall and Spring); the first workgroup starts today and is on Full Service Partnership – shared interest survey link in the chat
  - Guidelines proposed include:
    - 10-12 participants to allow for deeper engagement
    - "First-come, first-serve basis" based on the completion of an interest survey.
    - If we receive more than 12 survey responses, a selection group will review the surveys and prioritize lived experience and cultural diversity
- **Public Input**
  - Brandi: I filled out the survey [FSP Workgroup Interest Survey] and have not had a follow-up
  - Lanajean: have you picked the participants [of the FSP Workgroup] yet?



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- We will be reviewing the surveys next week with a Selection Group (MHSARC Co-chairperson, MHSA Manager and an MHSA Steering Committee volunteer)
- We intentionally did not close the interest survey to allow folks that are not able to attend today for the FSP Workgroup kick-off to still participate; we will make the recording and materials available for folks that could not participate today.
- You will hear from us before the next October workgroup
- Doris: We currently do not have an MHSA Steering Committee member volunteer for the Selection Group
  - Michael: I also serve on the Commission, can I support the Selection Group? How does the “first-come-first-serve” work if we want to ensure diversity.
  - In this case, because we have over 24 interest surveys, we will take a look at the first 12 that completed the survey and will build off of that to ensure there is diverse representation across organizations, lived experience and cultural perspectives. This means that someone who is on the first 12 list may not be selected.
  - Mary and Juliana also volunteered for the Selection Group via chat; Doris will reach out after the meeting to find a date/time to review interest surveys.

- **MHSA Full Service Partnerships (FSPs) - *Third Sector consultants*** 20 min
- FSP 101 and Background
- Statewide FSP Project
- San Mateo County Client/Families and Provider Input
- Public Input 30 min
- **Introductions**
  - Aurelle Amram, Director with Third Sector, based in San Francisco. Leads mental health work across California and the country. Worked with Los Angeles County on transforming their Full Service Partnerships so that clients aren’t falling through the cracks; a three-year project that led to the Statewide work.
- **Statewide Collaborative – Multi-County FSP Innovation Project**
  - Overall goal within SMC is to implement a more uniform data-driven approach to FSPs; using one-time CSS unspent funds in SMC
  - Project originated from the work in LA County; when look at data and anecdotal data on the ground, note that some counties have not been able to meet the full intended outcomes of FSP and there are challenges understanding impact.
  - LA brought in Third Sector to help transform FSP to be outcomes oriented and data informed while still respecting the spirit of doing “whatever it takes” to support clients



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- 6 counties came together (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) with support from the MHSOAC, CalMHSA and RAND as an evaluator to create consistencies and improve FSPs
- Counties will have increased capacity for collecting and using data to improve FSP services. Clients will receive data-informed and evidence-based services. Lessons and tools can be shared statewide to benefit statewide FSP services. Goals include:
  - 1) Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework
  - 2) Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders
  - 3) Improve how counties define, track, and apply priority outcomes across FSP programs
  - 4) Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools
  - 5) Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback
- Timeline: 4.5-year project. Began in 2019 working with MHSOAC and interested counties in developing project plan. Winter 2020 began landscaping assessment to learn about FSPs in each county (differences, similarities and challenges) Fall 2020 started 1-year implementation phase, which is coming to an end now. Sustainability planning will begin soon. 2022-24 RAND will evaluate the impact of this Third Sector process
- Because this project is focused on continuous improvement, there's still a lot of opportunity to gather input and inform direction of SM FSP's moving forward.
- **FSP 101**
  - FSP's deliver a "whatever it takes" approach to community-based mental health services for SMI/SED individuals
  - Serves over 60,000 individuals and families across the California
  - Counties are required to direct the majority of MHSA CSS funding to FSPs
  - FSP providers deliver a wide array of services – many modeled after national Assertive Community Treatment (ACT) and AB2034 (pilot of recovery approach targeting homeless SMI)
    - Services include therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.



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- Outcomes include consumer-centric services to achieve goals identified in individuals' Individual Services and Supports Plans (ISSP).
- Statewide challenge: counties have flexibility in how they operate FSPs and clients need a variety of different services at entry and during the course of their journey. How do we build consistency, measure success, and understand statewide impact?
- **Participating agencies**
  - 6 counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) + Lake and Stanislaus joined in August 2021
  - Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.
  - RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.
  - CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.
  - The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process, rural Counties and the development of statewide project resources and Learning Community events.
- **Questions**
  - Is the work only for adult FSP programs?
    - SMC chose to focus on both youth and adults. Counties got to choose what groups they focused on. The statewide work to define shared measurements strategies are focused on adults but, the second wave will focus on youth.
  - I would like to receive a PDF copy of this presentation. Can you share the slides with us?
    - Slides are posted on the MHSA website, under Announcements: [www.smchealth.org/MHSA](http://www.smchealth.org/MHSA)
  - What is CSS?
    - CSS is the Community Services and Supports component of MHSA. 76% of MHSA funding must be dedicated to CSS; 51% of CSS must fund FSPs.
  - Regarding data gathering, I want to understand more about this process: is RAND in the middle of this or do they come in after we are done with the process. What are some of the data that is already available.
    - Qualitative data – feedback from providers and consumers in the programs have informed a lot of the recommendations. This was conducted by Third Sector. Also looked at MHSA annual updates, three-year plans, cultural competency reviews and from Counties directly



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- RAND will receive quantitative data to evaluate the impact of the process, directly from the County. Aggregate data will be shared across counties.
  - What does it mean that we used CSS dollars in our counties? Why did we use CSS funds?
    - Our INN monies were already allocated when this opportunity came to us so, in SMC we used unspent MHA CSS dollars through a stakeholder process that prioritized a \$12M One-Time Spend Plan back in 2019-2020
  - Will SMC retain its individual rights on how we execute FSPs
    - Absolutely. This whole project has been about retaining local flexibility while identifying areas for statewide consistencies
  - Did you say that a goal is if a person in FSP moves from one county to another in California, he/she will be able to get consistent care?
    - Counties are retaining local control while they learn from each other. If someone moves from one County to another, they should receive consistent high-quality care. We have been very thoughtful about what should be consistent and what should be localized. These questions has not been answered before and it's part of the innovation.
- SMC-focus
  - Working on some things at the statewide level (shared outcomes, measurement strategies to compare data)
  - At the statewide level we are not coming up with eligibility guidelines and other local implementation strategies
  - SMC implementation activities have included:
    - Revise county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.
    - Develop minimum service requirements (baseline foundation) of FSP to adopt as official guidance. E.g.: % of field-based services, telehealth options, housing and employment services offered, peer supports available, etc. Whether a client accepts the service or provider offers other services, that is the flexibility of this project.
    - Develop standardized graduation guidelines to support staff in making individual stepdown and graduation



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decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of “stability” and discussion prompts.

- SMC activities have included:
  - Co-creating Child/Youth/TAY FSP Service Exhibit with San Mateo BHRS staff that will become the basis for the new Request for Proposal to procure for Child/Youth/TAY services.
  - Sharing best practices from Los Angeles County Department of Mental Health to inform the revised Adult FSP Service Exhibit that will become the basis for the Request for Proposal to procure for Adult services.
  - Using provider and client interview and focus group feedback to inform Service Exhibits and RFPs. What’s worked well, what hasn’t.
  - Developing standardized graduation readiness guidelines to be used in conjunction with new graduation / stepdown process. Not about forcing anyone out of FSPs but, want to provide consistency in when to consider transitions and provide the supports needed for a warm hand-off (readiness indicators and guidelines for best practices).
  
- SMC Next Steps include:
  - Finalize Child/Youth/TAY and Adult Service Exhibits and Requests for Proposal.
  - Continue gathering local input to prioritize local FSP outcomes and provide input on FSP services for ongoing quality improvement. Through upcoming FSP Workgroup
  - Developed standardized graduation/ step-down process that can now be used across all FSP providers in the county.
  
- Stakeholder engagement in SMC included:
  - FSP clients and staff interviewed Aug-Sep 2020 to guide selection of implementation activities (13 clients; 8 staff) and Mar-Apr 2021 to inform the RFP (14 clients; 12 staff).
  - Clients were interviewed over the phone and received \$25 gift card. Hundreds of clients interviewed across the State
  - Staff focus groups included staff that work with clients directly and heard about services that are working and challenges/barriers





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- The full FSP Focus Group Summaries are available on the MHSAs website, under Announcements and our MHSAs Steering Committee Meeting Materials, [www.smchealth.org/MHSA](http://www.smchealth.org/MHSA)
- Learnings/Highlights included:
  - Therapy/psychiatry should be more readily provided in-house and consistently within FSPs
  - Importance of Peer and family advocates; how we could improve staffing issues and making sure we address attrition and career pathways
  - Helpful to leaving FSP earlier in the program, not necessarily a forever program so being able to have graduation conversations sooner. What will it look like when a client is ready to graduate?
- Questions and Input
  - What does it mean to graduate? To be self-supporting? Or to just be more engaged with the community? I think what it means to “graduate” might vary for each person.
    - “Graduation” is used because it is important to celebrate hard work and thinking about when clients are ready to move to a less intensive level of care; “step-down” is another word used for stepping down to lower level of care.
  - Comment: regarding seeking peer opinion about this program reminds me that the law enforcement and mental health pilot program [crisis response] was created completely behind closed doors, no public input was requested nor made available. Santa Clara County spent months getting public input on their mobile mental health pilot program that will roll out and has no embedded police component. The program was designed by local mental health programs and staff.
    - There is so much interesting work across the state and it will be beneficial to share and compare across similar indicators
  - Were clients interviewed who had “graduated”? Clients who “dropped out”?
    - Yes, we did interview clients who had graduated or stepped down to lower levels of care to find out what worked well. We did acknowledge the inherent bias in the data because couldn’t track down clients that dropped out due to negative reasons. Recognized bias in the type of feedback we sought.
  - Regarding step-down of care and supporting clients in their transition, has Third Sector begun that process or are we just



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beginning now. Will there be opportunities to share about this and hear about what those indicators currently are?

- We are looking at this in two stages: 1) what is the process for stepping a client down once the decision is made that a client is ready to step down? How is FSP provider coordinating with new provider, are they attending sessions with the client, meeting one-on-one with the provider? What does warm hand-off look like? 2) readiness indicators of how you know when the decision to graduate should be made. This will be explored with the FSP Workgroup in future meetings. So, part of the work has already begun and part of it is happening through the FSP Workgroup. We will share best practices and input from academics and other counties during the October FSP Workgroup.
- Apparently, the schools have major say re: continuing FSP vs graduating. Is this due to funding?
  - We have been discussing with the Child/Youth team on how to enhance coordination between the FSP services and the school-based services team, if there are additional services being provided at schools and trying to put more consistency in what it would look like for an FSP team member to coordinate with the school district or school care team and that it's all billable.
  - Participant comment: My experience is that schools are fairly uninvolved with the FSP's and they don't tend to impact that decision. Just my experience.
- School districts filed due process to discontinue FSP. Administrative judge ruled "no way". School district discontinued FSP anyway.
  - We will follow-up on this comment. I agree that this has not come up in our local conversations but, I will follow-up to make sure we can clarify.
- Did you mention standards for people who may not be in a step-down position... are there going to be standards of continued care for them as well?
  - Yes, some of the workflows include looking at readiness indicators every 3 months in partnership with clients and families; review goals and decide collectively using data. If not sure then routine care will continue. Goal-oriented care, FSP services will continue until client is ready; not about a timeline, it's about checking in with the client and the families.
- Older adults – there's an optimism with how we are discussing graduation ("you're not quite there but, you will get there"). But, for older adults, housing may be jeopardized and may not have the



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ability to step-down; what would be reassuring for those that may not get better.

- We are focused on giving FSP providers the tools to have those conversations with clients and let them have the judgement about whether someone should or should not move out of FSP; not mandating that clients graduate. If provider is working with an older adult, they will continue services for them.
- There's standard for stepping down, will there be standards for those that don't step-down. Are there enough clients that fall into that category?
  - We know that most clients don't step down. The average participation is 1-2 years. Quarterly, there will be conversations about stepping down. We can discuss this further in the FSP Workgroups and especially as it relates to youth vs. adults and older adults.
- I would like there to be some consideration of being able to "step up" where peers can transition from clients into peer providers. . .giving them opportunity to become employed into the field.
- We're talking about transition moving in one direction. Are there conversations about transition moving bi-laterally? What we observed in 05-07 (as part of the AB2034) is that many clients who stabilized and were transitioned down, decompensated rapidly and aggressively. Those that were kept with their agency, even if moved to a lower level of care within that same agency, had a higher success rate in that transition. We (Telecare) held on to some clients within our agency in lower levels of care for years and then age-related decline issues led to moving them back up to higher level of care. Is there conversation statewide about this?
  - Transition back and forth comes up in every FSP conversation. We are thinking about how to address it but, in SMC we are not addressing it explicitly.
- In SMC, we have not seen a lot of youth that move from the youth/TAY FSP into the adult FSP. What work is being done in integrating that fluidity?
  - There is not good quantitative data being collected about outreach and engagement in any County. Who did or did not get into FSP? Can we get a quantitative foundation of who was enrolled in FSP or who were not eligible, where are referrals coming from and what are they dynamics? WE are starting to gather this data.
  - Qualitative data has pointed to confusing service expectations about transferring a client when they turn 26 years of age to the adult FSPs or keeping them if they are



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being successful. Where is there flexibility on this and what should outreach look like.

- Participant comment: It's incredibly difficult to track community outreach as most of the outreach in our work happens on the ground and we do not have the capability to follow the person from point of contact to access of care.
- For service requirements, will Third Sector look at requirements from both staff perspective and client's perspective on eligibility requirements? There is a discrepancy between providers and consumers. On the medical side things are still being updated and re-evaluated as to when clients can be graduated.
  - We asked this of consumers during the interviews. Did you feel it was easy to get into the FSP program, what questions were you asked, what was the experience like, how did you hear about the program, how would you know when you are ready to graduate, how would you feel, have you talked about this with your clinician, how did you make that decision, how did it feel, did it go well, if not, what can we improve?

### 5. Adjourn

- Feedback survey for this meeting available here:  
[https://www.surveymonkey.com/r/MHSA\\_MtgFeedback](https://www.surveymonkey.com/r/MHSA_MtgFeedback)
- FSP Workgroup interest survey is open through Friday, September 3, 2021
- Next Steering Committee meeting is scheduled for December 10, 2021

**\* Public Participation:** All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide Public Comment and input. You can also submit questions and comments in the chat; these will be addressed on a "first-come, first serve" basis. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes.

The meeting will be recorded. Questions and public comments can also be submitted via email to [mhsa@smcgov.org](mailto:mhsa@smcgov.org).

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**\*REMINDER – Please Complete the Steering Committee Feedback Survey**

[https://www.surveymonkey.com/r/MHSA\\_MtgFeedback](https://www.surveymonkey.com/r/MHSA_MtgFeedback)





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### ATTENDANCE

There were up to 25 participants logged in to the Zoom app. Below is a list of attendee names as recorded from Zoom; call-in numbers are typically unidentifiable.

#### **MHSA Steering Committee Co-Chairpersons**

1. Jean Perry (MHSARC)
2. Leticia Bido (MHSARC)

#### **BHRS Staff Supports**

- Doris Estremera (MHSA Manager, BHRS ODE)  
Sylvia Tang, she/her (BHRS ODE)

#### **MHSA Steering Committee Members**

3. Jairo Wilches (BHRS OCFA)
4. Juliana Fuerbringer
5. Mary Bier
6. Michael Krechevsky
7. Michael Lim (MHSARC)

#### **Presenter(s)**

- Aurette Amram, Third Sector

#### **Participants**

8. Kevin Jones
9. Georgia Peterson
10. Suzanne Moore
11. Tet Madrid
12. Amanda Russell
13. Brandi Machado
14. Eddie Flores
15. Susan Cortopassi
16. Noelle Beaver
17. Lanajean Vecchione
18. Eddie Flores
19. Pat W
20. Chelsea Bonini
21. Claudia Saggese (BHRS OCFA)