



# Answers to Mental Health Board Questions

SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

## Introduction

The following are answers to questions submitted by the members of the Mental Health Board (MHB). The questions have been re-ordered, but have not been altered. Questions 1 through 4 are general questions about the Innovation (INN) component. These questions are answered in this document and will be discussed during the July 19, 2010 Stakeholder Leadership Committee (SLC) meeting.

Questions 5 through 10 applies to each individual INN project. Thus, while an introductory answer is given in this document, project-specific answers can be found in each project's "Aim Statement," Work Plan Narrative (Exhibit C) or Work Plan Description (Exhibit D). In addition, these questions will be further addressed during the stakeholder's presentations.

Question 11 is in regards to the Community Services and Supports (CSS) Plan. The question is answered here and will be discussed during the July 19, 2010 SLC meeting.

### **1. Once the county receives these MHSA Innovation Project dollars from the State, does the MHD have jurisdiction to change the projects, or redirect the funding? Or is the funding locked into these project designs? If it can be changed how will all concerned be informed?**

*When INN projects are approved, the County is authorized to incur expenses against each project, and receives the total funding requested for the approved projects for a specific fiscal year. As with the CSS and Prevention and Early Intervention (PEI) components, the MHD is authorized to move funds between INN projects and to adjust services so long as the target population and the overarching goals of the project(s) are not changed and so long as the project continues to meet the State's definition of "innovation." For example, during the procurement process, one project may cost less than initially budgeted, while another project may cost more. In this instance, the MHD can alter funding allocations for each project. The MHD cannot redirect unexpended funds into a new project altogether; however, it can choose to terminate a project after consultation with stakeholders.*

*The nature of the INN projects and the constant evaluation and assessment necessitate some flexibility in program design. It is anticipated that the Learning Advisory Committees will be engaged in improving/adjusting the program design throughout the life of the projects.*

*The MHD anticipates that reporting on the progress of each INN project quarterly to the SLC and MHB. The need for significant changes to funding could be discussed in those forums.*

**2. What happens to the MHSA Innovation monies if a project is not supported by the MHB?** *If a project is not supported by MHB, then the MHD must decide whether or not to submit the project to the Board of Supervisors. If a County-submitted project is not approved by the State, then the funding that was allocated to that project remains at the State. All INN funds are subject to reversion if not expended within three years. Based on when the funds were made available, the published INN planning estimates (annual funding allocations) and when the INN guidelines were issued, the County must expend approximately \$6.5 million by June 30, 2012. For example, if only \$6.0 million are expended by June 30, 2012, then \$500,000 will revert to the State for allocation to all Counties using existing distribution formulas.*

**3. Does the funding of these projects include funds for location, business expenses, needed insurances, transportation, forms, advertising etc...?** *The expenses for each project vary, and are based on the project's services or activities. As part of a new requirement from the OAC, the MHD has inserted a budget narrative for each of the projects including one for administration. The expense category "Operating Expenses" is very broad, and can include all of the expenses listed in the Mental Health Board's question. In addition to very specific project needs, a project's operating expenses include office supplies, office equipment, shared facility expenses, postage, etc.*

**4. What structure is in place to manage, oversee and steward the projects, by the MHD?** *In addition to personnel directly associated with each project (as described in the budget narratives) and existing MHD managers, the INN projects will be supported by the following.*

- *The MHD's Program Planning and Development Team, including the MHSA Project Manager and the Innovation Coordinator, is responsible for working with stakeholders and other staff to fully develop implementation plans and program designs once the projects are approved by the Board of Supervisors and the State. For both contracted and County-operated projects, the team plays a lead role in ensuring that all program issues – operational, financial, legal, clinical, evaluation, etc. – are identified and addressed. The Innovation Coordinator has primary responsibility for communicating lessons learned and reports to the State and to stakeholders, for supporting the development of the Learning Advisory Committees, for monitoring fidelity to the approved project, and for assisting the MHD incorporate lessons learned into the existing system of care. The team will also coordinate the development of new INN projects based on funding availability, system needs and stakeholder input.*

- *For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each LAC will be different, all will include consumers and/or family members, providers, system partners and MHD staff. Each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and*

outcome data. Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned.

- Throughout the process, each Learning Advisory Committee will be supported by a professional program evaluator who will be assigned to each project. This resource will need to be procured and deployed in support of each project. The evaluators will serve as an additional resource to the MHD's Decision Support team.

- In addition, the MHD will add 1.0 full time staff persons to both the Adult/Older Adult and the Family & Children Divisions. These two operating divisions are responsible for implementing and monitoring all program services. They assume a primary role once the services are ready to be initiated. The addition of two staff persons will ensure that the INN projects are implemented expeditiously and monitored regularly. Each "Project Coordinator" will be assigned several INN projects and will assist in supporting the Learning Advisory Committees. They will reassess the permanency of these positions upon completion of the initial projects since the projects are time-limited and because funding for the INN component will fluctuate significantly over the next several fiscal years.

**5. Why do these programs qualify as innovative programs?** A project meets the OAC's guidelines for being "innovative" if it 1) introduces new mental health practices/approaches, 2) changes existing ones, or 3) introduces new applications or practices/approaches that have been successful in non-mental health contexts. How each project meets these requirements is answered in the "Contribution to Learning" section of the Work Plan Narrative (Exhibit C) and will be discussed in more detail during each project's presentation.

**6. Where will the projects be located?** Although the specific location for each project has not yet been determined, the general method for delivering the service/activity – at a central location, at clients' residences, in pediatrician's offices, etc. – is identified in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.

**7. Would the project have staff members who speak languages other than English and be culturally sensitive?** While the specific language requirements will vary by project, the MHS General Standards require the services to be provided in a culturally competent manner. At a minimum, the MHD is responsible for ensuring that services can be provided in the threshold languages. The answer to this question for each specific project can be found in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.

**8. What outcomes measures will be used to evaluate the projects? Why can these outcomes not be identified and discussed before the start of the projects? (Each project under Project Measurements has “Data Collection and Quantitative and Qualitative analysis” but does not list what will make this up and what results would be considered a success and what would be considered a failure.)** *The Work Plan Narratives have been revised to include statements that articulate each project’s aim and success measures. These measures and the methods for their collection and evaluation will be finalized in conjunction with the Learning Advisory Committees prior to the initiation of services. The answer to this question for each specific project can be found in the project’s “Aim Statement,” Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

**9. How will these projects sustain themselves after the funding ends in 2 to 3 years?** *While INN funds cannot be used to sustain a project indefinitely, the Learning Advisory Committees, stakeholders and the MHB will be involved in recommending how the lessons learned from each project can be “sustained.” As indicated in the “Timeline” section of each Work Plan Narrative (Exhibit C), this question will be taken up well before a project is scheduled to end. Although an obvious method would be to redirect other funds to an INN program/service, the results from an INN project could impact the system in ways that would require little or no County funding. For example, the lessons learned could convince providers to alter existing approaches or service delivery methods, change departmental policies, or access other funding sources. The methods specific for each project can be found in the project’s “Aim Statement,” Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

**10. What product or outcome is expected by the MHD from the MHSA Innovation Projects, and how will these impact the annual plan for future years?** *Each INN project is expected to contribute to learning by “providing an opportunity to try out new approaches that can inform the current and future practices/approaches in communities.” The lessons learned – from successes and failures – could be used to modify current practices or replace entire programs and services. Although not the focus of the INN component, each INN project will produce tangible benefits to clients and the system in the form of services, equipment, partnerships, training, new service delivery models and research. The “product” for each project can be found in the project’s “Aim Statement,” Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation. (Please also see question #9.)*

**11. Are the programs implemented as approved, (9 Strategic Plans)? What Quantitative Data is available?**

**A)** *As part of the County’s FY08-09 Annual Update, the MHD consolidated the original CSS Plan’s 20 work plans into nine work plans, which have mostly been implemented as approved. By implementation, the County is referring to the processes associated with the programs, services*

*or activities (such as needs assessments) that were identified in the original plan and/or as modified and endorsed by local stakeholders. Generally speaking, FSP, other direct service and outreach programs were implemented as approved. The MHD experienced some delays associated with contractual, logistical or procurement processes inherent in starting new services in a public mental health system. Other challenges resulted from the need to forge more formal collaborations with key system partners (juvenile justice systems, foster care systems, etc.) in order to integrate services. A summary of each CSS work plan, its target population, strategies and current programs is described in the “CSS Plan Summary Documents,” which has been provided as part of the SLC/MHB packet.*

*There are two key differences between CSS implementation and the approved plans. First, the original CSS plan called for the development of a time-limited pilot program to address “first breaks” or the “first onset” of mental illness among transition age youth. Since the CSS plan only allocated “one-time” funds for the program, the County determined that the intended goals of the program would be better met and sustained under the PEI component (see PEI Program/Project 3). Second, while the County has implemented one centralized Mental Health Urgent Care program, the original plan called for two additional smaller sites in the northern and southern regions of the County and for mobile crisis response capabilities. Both goals remain integral to increasing residents’ access to non-emergency mental health services. As MHUC operations are optimized, the County will develop appropriate implementation strategies in light of projected decreases in MHSA funds.*

*In addition, while the County has had success incorporating consumers and family members in direct service roles (80-90 individuals) and in system planning, staff and stakeholders acknowledge that the outcomes are far short of intentions. The County will continue efforts to develop more cohesive and robust family member-run and consumer-run programs. These efforts will be integrated with related programs under WET, PEI, INN and CFTN.*

**B)** *Currently, quantitative data is available, but with significant limitations. First, outcome data (changes for clients) is extremely difficult to obtain and present systematically. With significant effort, the MHD can provide outcome data for specific programs such as the FSP-90 program operated by Momentum for Mental Health. With even greater effort the MHD can provide some outcome data for very similar programs such as all FSP programs serving TAY. However, because the MHD is still developing standardized, global performance measures, outcome data for entire systems of care (e.g. all adults) cannot be provided because of differences in service levels, need, budgets, etc. Requests for outcome data should be made for specific programs with time dedicated for in-depth presentations.*

*Second, while utilization data for treatment services are available, utilization data for outreach and engagement services are generally softer and more prone to error. For example, the ECCACs diligently track the services they provide, but since they must do so manually, there is often greater room for error. Similarly, there are challenges related to determining the number of unduplicated clients that CSS work plans or programs serve. Quarterly, the MHD reports on*

*the number of clients served by each CSS work plan. However, there is often significant overlap between CSS work plans and between CSS and “non-CSS” programs. As a result the reported numbers are generally very useful for understanding the progress of specific programs, but are less useful when trying to gauge the progress of an entire work plan. For example, CSS Work Plan A-01 consists of nearly \$24 million in programs and services that are both stand-alone and augmentations or expansions of existing programs.*

*While quantitative data is limited, it does exist, and can be utilized to develop informative reports. Both the MHD and stakeholders should continue to refine reports, improve capabilities (e.g. redeploying an Electronic Health Record), standardize performance measures, and communicate expectations and limitations in order to make the best-informed decisions as possible.*