BEHAVIORAL HEALTH ADVISORY BOARD

General Meeting

Monday, March 21, 2022, 1:00 – 3:30 PM

VIRTUAL MEETING VIA ZOOM

Zoom Participation

The following information referenced below and at the end of the agenda is provided to you in support of your attending the upcoming BHAB General Meeting via Zoom:

Join the Zoom meeting in the following way:

Join Zoom Meeting: https://us02web.zoom.us/j/83332714732?pwd=bE43OUJqRHhHa0ExSlR5L1VLMWMyQT09
Meeting ID: 833 3271 4732
Password: 149553
Dial-In: 669-900-9128

AGENDA

I. Call to Order

II. Board Member Roll Call

III. Welcome and Introductions

IV. Approval of the Agenda – **ACTION** (Roll Call)

V. Approval of the February 28, 2022 Minutes – **ACTION** (Roll Call)

VI. Public Comments (3 min. per speaker)

VII. Chair Comments (10 min.)

VIII. Director's Report – Dr. Sevet Johnson (10 min.)

IX. Board Member Comments and Announcements (10 min.)

X. Secretary's Report – Janis Gardner (5 min.)

XI. BHAB Committee Reports (5 min each)

A. Adult Services Committee (March 3 meeting) – Nancy Borchard and Gain Brooking, Co-Chairs

B. Prevention Committee (March 8 meeting) – Janis Gardner, Chair

XII. Old Business

A. Needs Assessment – Discuss Status of Request for Proposal (RFP) Development – Michael Rodriguez, Chair (5 min.)

B. 2021 Data Notebook – Review and Approve Finalized Report for Submission – Michael Rodriguez, Chair - **ACTION** (Roll Call) (10 min.)

C. Disparities Reduction Committee – Update on Formation – Marlen Torres, BHAB Member (10 min.)

XIII. New Business

A. Brown Act Public Emergency Allowances / Teleconferences – Requirements for Local Boards and Commissions / Continue to Meet Remotely or Via a Hybrid Remote/In-Person Model – Michael Rodriguez, Chair – **ACTION** (Roll Call) (5 min.)

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. **Public comments on agenda items must be made prior to board member deliberations of agenda items**. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

B. Public Hearing to End 30-Day Public Comment Period on the Mental Health Services Act (MHSA) Managing Assets for Security and Health (MASH) Senior Supports for Housing Stability Innovations Project (February 18 – March 21) – Michael Rodriguez, Chair – **ACTION** (Roll Call) (10 min.)

C. Inpatient Psychiatric Unit (IPU) and Crisis Stabilization Unit (CSU) – Operations Update – Sherri Block, MN, RNC – Associate Chief Nursing Officer/Ventura County Medical Center & Santa Paula Hospitals (10 min.)

D. Appoint Chair for the Transitional Age Youth (TAY) Committee – Michael Rodriguez, Chair (5 min.)

E. Community Engagement at BHAB Meetings – Discuss Improvement Methods – Michael Rodriguez, Chair (5 min.)

F. Announcements – Janis Gardner (5 min)

G. Presentation Requests

H. Recognition Award Recommendations

XIV. Contracts

Board of Supervisors Approved Agreements – February 8, 2022

1. Third Amendment to the Agreement for Interpreting and Translating Services with ALIT.
2. Fifth Amendment to the Agreement for Medical Personnel Temporary Staffing and Recruiting Services with Maxim.
3. Participation Agreement with the CalMHSA for Peer Support Specialist Certification Services.
4. Seventh Amendment to the Agreement for Medi-Cal Specialty Mental Health Rehabilitation Center (MHRC) Services with Golden Hillmont House MHRC, LLC.
5. Sixth Amendment to the Agreement for Medi-Cal Specialty Mental Health Care Short-term Crisis Residential Recovery Treatment (CRT) Services with Golden Ventura CRT, LLC.

XV. Public Comments (3 min. per speaker)

XVI. Adjourn

Next Meeting: Monday, April 18, 2022

All agenda reports and supporting data, including those filed in accordance with Government Code Section 54957.5 (b) (1) and (2) are available from the Behavioral Health Advisory Board Assistant at bhabadmin@ventura.org or in person at Ventura County Behavioral Health, 2nd Floor, 1911 Williams Drive, Oxnard, California. The same materials will be available and attached with each associated agenda item, when received, at the following website: www.vcbh.org/en/behavioral-health-advisory-board-meetings.

Welcome to the meeting of the Behavioral Health Advisory Board of the County of Ventura. The following information is provided to help you understand, follow, and participate in the Board meeting:

Join the Zoom meeting by clicking the link provided on the agenda at the scheduled time and date. Zoom will initially start with a **waiting room** — you will be admitted into the meeting room when the meeting starts. All participants are muted upon entry to minimize any unintended disruption of background sounds. Please keep yourself on mute unless you are speaking.
Note: The meeting is recorded.

Public Comments

- The Behavioral Health Advisory Board (BHAB) welcomes comments from the community, consumers and family members.
- The BHAB operates under the Brown Act. This requires that all meetings be open meetings, with the agenda and minutes posted. A public comment period will be provided on all meeting agendas.

- Due to confidentiality laws, the Board is unable to respond directly to a public comment or to discuss client-specific issues without proper releases from the individuals concerned.
- At all BHAB meetings, the BHAB Assistant provides a Grievance Form for individuals who have concerns. The form is reviewed promptly by VCBH Quality Management. Individuals can also contact the BHAB Assistant to request a VCBH Grievance Form outside a BHAB meeting or call 1-888-567-2122.
- Individuals who have further concerns are welcome to return to the BHAB for assistance.

Public comments may be provided using one of the following options:

1. Email or Mail Public Comment in Advance of the Meeting

To make a written public comment, you must send an email to bhabadmin@ventura.org, with the specific agenda item or topic, if a general comment, by no later than 10:00 AM on the day of the BHAB meeting. Your written public comment may also be mailed to the following address and must be received by the BHAB Assistant no later than 10 AM on the day of the meeting:

BHAB Assistant
1911 Williams Drive, Suite 200
Oxnard, CA 93036

Please indicate in the subject line the agenda item number (e.g., Item No. 9) on which you are commenting. Your written public comment sent via email or regular mail will be distributed to the BHAB Members and placed into the item's record of the meeting.

Or

2. Video Public Comment using Zoom

You may use the raise hand feature when the Chair invites public comments in the following ways:

If you are running an older version of Zoom, you can raise your hand by clicking on the Participant button at the bottom of the Zoom screen and then click on the raise hand feature in that participant window.

If you are running the most current version of Zoom (5.4.9 and above) you can raise your hand by clicking on the Reactions button and then clicking on raise hand feature. Your hand will appear in the upper left-hand corner of your individual Zoom window as well as the participant window.

Call-In Public Comment using Zoom

If you are joining the meeting by telephone only, you can join the comment queue by pressing ***9**. When it is your turn to make your comment, press ***6** to unmute and then again to mute yourself after speaking.

Note: Your raised hand will appear TO THE HOST in the order it was received.

Comments are taken in the order they are received in the queue/participant window. When it is your turn to make a comment, you will be asked to unmute yourself. **Public comments may be up to 3 minutes during the public comment periods, or before an agenda item, with a cumulative total time not to exceed 5 minutes.** The assigned timekeeper will track each public comment time as well as the total time per speaker. When your time is up, the timekeeper will interrupt to let you know that you have reached the 3-minute maximum as well as when you have reached your total allotted time. At the end of the three minutes and/or allotted time, the next person in the comment queue will be invited to speak.

REMINDER: In order to minimize distractions during public meetings, all personal communication devices should be turned off or put in a non-audible mode.

Director's Update

BHAB General Meeting 3.21.22

March has the following days of significance to highlight:

Women's History Month & Social Workers' Month
March 8, International Women's Day
March 22-28, National Alcohol and Drug Facts Week
March 31, Cesar Chavez Day

California Advancing and Innovating Medi-Cal:

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots (including but not limited to the Whole Person Care Pilots (WPC), Health Homes Program (HHP), and the Coordinated Care Initiative) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Regarding County Mental Health Plans, the primary focus areas are:

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

DHCS formally released the CalAIM proposal on October 29, 2019, at the Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) meetings. Between November 2019 and February 2020, DHCS conducted extensive stakeholder engagement for both

CalAIM and the renewal of the federal authorities under which Medi-Cal operates (i.e., 1115 and 1915b waivers).

DHCS postponed the planned implementation of the CalAIM initiative, originally scheduled for January 1, 2021, so that both DHCS and all of our partners could focus their limited resources on the needs arising from the public health emergency due to COVID-19.

DHCS released a revised CalAIM proposal on January 8, 2021. **Revised CalAIM Proposal**.

General Updates:

- The Administration introduced a CARE Courts Proposal in early March. Community Assistance, Recovery and Empowerment (CARE) Court is a new framework to get people with mental health and substance use disorders the support and care they need. CARE Court is aimed at helping the thousands of Californians who are suffering from untreated mental health disorders leading to homelessness, incarceration or worse. California is taking a new approach to act early and get people the support they need and address underlying needs. To learn more about this proposal, please visit: https://www.chhs.ca.gov/care-court/
- The Quality Management Action Committee (QMAC) meeting schedule and format has been updated to allow for more in-depth data review and discussions. Now, in addition to large group meetings, smaller work groups will take place bi-monthly. The first smaller, QMAC Work Group will be towards the end of March. A Doodle poll to request participation and gather date preferences from QMAC members will be sent soon. The next all member QMAC meeting will be in September, TBD. If anyone is interested in joining or would like to recommend someone, please email vcbh.quality@ventura.org.
- We would like to provide the link to the webpage where the most recent VCBH EQRO reports can be viewed:
  https://vcbh.org/en/about-us/reports-performance
- We would also like to provide a link to the webpage where the most recent VCBH Executive Leadership Org Chart can be found:
  https://vcbh.org/en/about-us/about-vcbh

Adult Services Division:

- Both operations and fiscal staff continue to explore ways to maximize the potential infrastructure funding under the State's $2.2B Behavioral Health Continuum Infrastructure Program. There is the potential to fund construction/repurposing of physical plants to be use for both treatment facilities and adult residential facilities. As noted in the past, the deadlines for submissions are tight with a strong emphasis on funding for "launch ready" projects, but we are actively pursuing a few different avenues.

Youth and Family (Y&F) Services Division:

Division Highlights

- The California Institute for Behavioral Health Solutions (CIBHS) has outreached to VCBH to present virtually at their annual EBP Symposium in June. CIBHS found the Healing the Soul project presented by Sandra Barrientos and Vanessa Martinez on a website and is specifically

requesting to have them present at this year's conference. They would be sharing about the program as part of a keynote panel presentation.

Initiatives and Progress

- The Y&F Division leadership continue to collaborate in strategic planning with agency partners to implement a shared Integrated Core Practice Model as part of AB 2083 MOU (Wellness System) deliverables.

Collaborations

- In partnership with VCOE, VCBH Y&F Division is collaborating with Wellness Centers to provide prevention and early intervention services in eight different high schools across the county. 208 referrals from the commencement of the school year Aug 2021 to date.
- The Y&F Division is collaborating with the Adult and SUTS Divisions, Beacon Health Options and Ventura County Office of Education (VCOE) to present on the MH Continuum of Services for youth in Ventura County. Presentation is slated for March 29 and is geared to all levels of student-serving staff in VCOE.

Training & Conferences

- In collaboration with VCOE, VCBH ERSES staff participated in a Social Emotional services training for Santa Paula Unified School District on March 14th. This is in addition to the yearly all-Districts training.
- VCBH CalWORKs will be facilitating four Life Seminars for CalWORKs participants on March 28th and March 31st. These seminars focus on various topics from Self Care, Parenting, to communication. We hold these seminars twice a year (winter and spring) and they are open to all CalWORKs participants.
- VCBH CalWORKs will be conducting a trial workshop for the Spanish speaking CalWORKs population, scheduled for March 25th. This is a workshop that was created for a SELPA presentation and a similar need was seen for our population. If there is a positive response the team will create a series of workshops in Spanish for our CalWORKs population.

Substance Use Services (SUS) Division:

Substance Use Prevention:

- The latest Special Report from the Office of the Medical Examiner on drug overdose deaths in 2021 provides more evidence of the impact that Fentanyl and Methamphetamine are having locally. As the Board Members know, the report showed a dramatic increase in accidental overdose deaths- a rise of 66 cases in one year; from 203 in 2020, to 269 in 2021.During the same period (CY 2021) VCBH SUS Prevention efforts also dramatically increased, including expanded Overdose Prevention with Naloxone, to reach highest risk groups.
    - Over calendar year 2021, we increased the number of overdose prevention sites from 38 to 49 locations, making more naloxone available countywide.
    - During 2021 we had 1,171 OD rescue kits distributed to residents at high risk for overdose, and 491 documented opioid overdose reversals with Narcan ®. That is, the

number of deaths would likely have been even higher were it not for the coordinated efforts of agencies training residents to respond to an overdose.

- "**Meth: Don't Buy the Lie**" media countywide. During CY 2021, VCBH used a combination of digital and print media to reach residents in both Spanish and English about risks. During this period the campaign tallied 609,000 impressions, via digital audio and social media, such as Snapchat, and also featured in outdoor media, including mobile billboards. See www.TalkingAboutMeth.org
- Expanded prevention messaging about Methamphetamine—and the risk that Fentanyl may be added to any street drug—will launch in April, and continue through the Summer, thanks to Supplemental Funding recently authorized by the Board of Supervisors.

Drug Medi-Cal Organized Delivery System (DMC-ODS):

- SUS Administration in collaboration with California Consortium of Addiction Programs and Professionals (CCAPP) and the National Alliance for Recovery Residences (NARR) completed Recovery Residence Housing training on February 23 and 24th. Training was provided to interested potential providers and included information on recovery residence basics, legal and ethical considerations, how to apply for and optimize county contracts. The RFP is scheduled to open on April 1, 2022.
- Medi-Cal Contingency Management Pilot Program Application was accepted and approved by DHCS. Ventura is one of 7 Counties that will start the pilot program in July 2022. Contingency Management (CM) is an EBP that provides motivational incentives for nonuse of stimulants. CM repeatedly has demonstrated robust outcomes, including reduction or cessation of stimulant drug use and longer retention in treatment.

Substance Use Treatment Services (SUTS):

- VCBH SUTS and CFS Family treatment court hosted a panel discussion today featuring Dr. Vlaskovits, Dr. Kahn, Dr. McDuffie to discuss Medication Assisted therapies. Sober living providers were invited to attend for discussion and Q&A. We had 32 participants attend. Dr. Vlaskovits presented recent data on the dangers of Fentanyl and the need for medications.

Administration:

CalAIM

- The CalAIM unit (California Advancing and Innovating Medi-Cal) continues to coordinate CalAIM efforts across the department. A CalAIM Implementation lead team, which includes mangers from various functional areas, meets weekly to analyze guidance issued by the Department of Health Care Services and to further plan how to successfully implement upcoming policy changes. VCBH successfully implemented the CalAIM updated criteria for access to Specialty Mental Health Services that became effective on 1/1/22. Specifically, VCBH staff worked to update policies, referral and assessment forms, and EHR applications. Provider trainings and on-going collaborations with contracted county partners and the local managed care health plan helped facilitate a smooth implementation experience. VCBH staff are now working with internal and external stakeholders to ensure timely implementation of policy changes that are effective 07/1/22.

Safety and Facilities

- Ongoing monitoring and compliance with DHCS IN-043 that requires all healthcare staff to be vaccinated, have a booster shot or have an approved exemption and be tested weekly. In addition, we have been coordinating and training with the County mass care and shelter group to provide disaster mental health and assistance in preparation of the next sheltering event. This will benefit the community in the event of a disaster requiring evacuations.

Contracts Team

- The Contracts Team is preparing to hold Spring Provider meetings in March and April to review contractors' FY 2021-22 performance for the second portion of the fiscal year and to discuss FY 2022-23 contract details. The Contracts Team has started contract season – the FY 2022-23 Contracts Budget has been completed and contract scopes of work and budget requests have been made to the VCBH Operations Managers and Contractors. Current fiscal year amendments are being processed to make any needed adjustments and increases before the end of the fiscal year.

Quality Assurance

- VCBH was awarded $1 million grant funding to implement the Mentored Internship Program (MIP) to assist in the treatment and recovery of clients with BH disorders and to strengthen and build the professional workforce.
- The QA Care Coordination (CC) team continues to facilitate all care coordination between VCBH and outside delivery systems and works to ensure beneficiary access to appropriate and culturally appropriate services within or outside the Network by identifying and mitigating barriers to access to timely services. The team receives grant funding to improve CC for hospitalized clients and has demonstrated improved outcomes in collaboration and coordinated discharge planning.
- Utilization Review is now conducting in-depth quarterly reviews that include supportive, feedback exit meetings to align with upcoming CalAIM documentation requirement changes. This process will enhance the identification of relevant UR strengths and areas for improvement and training.
- QA has initiated onboarding protocols to standardize training and support operations which includes provider hiring/onboarding checklists, training on important policies and procedures, and standardized welcome packets.
- QA continues to review, monitor and track implementation of and compliance with DHCS Information Notices in collaboration with inter-departmental stakeholders.
- QA is now facilitating quarterly VCBH management/CBO provider meetings, to provide ongoing training and updates on topics including updates on CalAIM implementation, compliance requirements, policies and procedures, QI and EHR.

Quality Improvement:

- The External Quality Reviews (EQRO) for Mental Health took place February 22-24, 2022. The draft report from the DMC-ODS External Quality Review (EQRO) held the end of November/early December was received and VCBH feedback has been sent to BHC. Once finalized, the report will be posted on the website.

- QI continues to implement 4 performance improvement projects (PIPs) that address areas for improvement such as no-show rates, initial and ongoing client engagement in services, and post-hospitalization follow-up, and recently received positive feedback on all PIPs from the state reviewers.
- QI is building out ongoing tracking and reporting of key performance metrics and are working with VC-Information Technology Services to design a public-facing data dashboard.
- To support Strategic Plan efforts, QI is working with department leads to deliver baseline data and develop methods for reporting progress.

Electronic Health Record (EHR)

- The EHR Team continues to collaborate on the CalAIM initiative with many VCBH partners. Currently we continue with our focus on the data sharing aspects of the ECM (Enhanced Care Management) initiative. ECM is the next-generation Whole Person Care initiative for California.
- We continue with our rollout of the new client chart structure for the Avatar user community. the improved interface allows clinicians to work with client chart details in a more efficient, and time effective manner.
- We are implementing an innovation to improve the notification to clinical staff when a current Full Service Partnership client experiences an engagement with law enforcement, the VCMC emergency room, HMIS, or psychiatric hospitalization. The new system being implemented triggers an alert notification to appropriate clinical staff when one of these engagements has occurred. This allows near real-time awareness of critical situations occurring regarding FSP clients, which their care team can then engage with.
- Preparatory steps are underway to implement a major release of our EHR application later in the year. This multi-month project will present new usability features in the EHR environment for all EHR users. An EHR project manager is currently in the project planning stage of this effort. The EHR client chart structure improvements mentioned in a prior point, is a prerequisite for moving into this new EHR environment.

CalHHS
California Health & Human Services Agency

CARE Court

A New Framework for Community Assistance, Recovery & Empowerment

CARE Court is a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

The CARE Court is a new approach and a paradigm shift

It connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. Housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.

CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration; this is based on evidence which demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community.

CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity – before they enter the criminal justice system or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. Although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions—this proposal aims connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness.

CARE Court engagement begins with a petition to the Court from a wide range of individuals, including care providers, family members, first responders, or counties, among others. CARE Court may be an appropriate next step after a short-term involuntary hospital hold (either 72 hours/5150 or 14 days/5250), an arrest, or for those who can be safely diverted from

a criminal proceeding. Remote or virtual proceedings may be especially effective for CARE Court participants.

Supporting a self-determined path to recovery and self-sufficiency is core to CARE Court, with a Public Defender and a newly established Supporter for each participant in addition to their full clinical team. The role of the Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible. The Care Plan ensures that supports and services are coordinated and focused on the individual needs of the person it is designed to serve. Oftentimes, care for this vulnerable population fails to bring together the clinical treatment and a plan for housing. The creation of a Mental Health Advance Directive will further provide direction on how to address potential future episodes of impairing illness that are consistent with the expressed interest of the participant and protect again negatives outcomes.

Accountability in CARE Court goes both ways

If a *participant* cannot successfully complete a Care Plan, the individual may be referred by the Court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under the presumption that no suitable alternatives to conservatorship are available. For individuals whose criminal cases were diverted, those proceedings will resume.

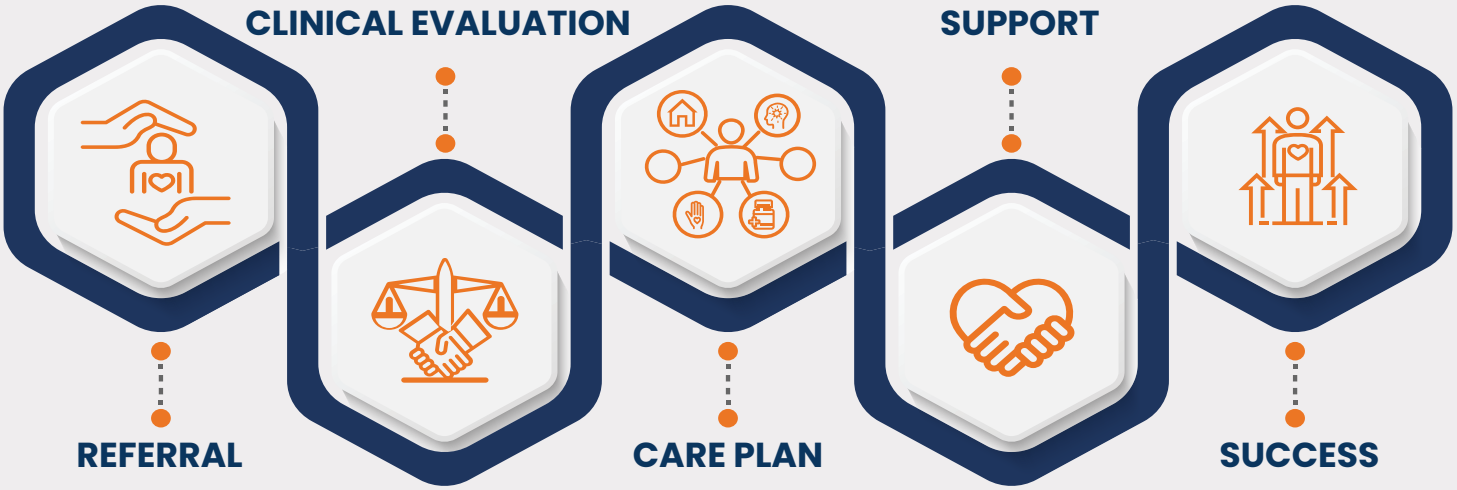
The CARE Court will also hold *local governments* accountable for providing care to the people who need it, using the variety of robust funding streams available to counties today. These funding sources include nearly $10 billion in behavioral health (including Mental Health Services Act, mental health realignment, federal funds) and the proposed $1.5 billion for behavioral health bridge housing, as well as various housing and clinical residential placements available to cities and counties under the Governor's $12 billion homelessness plan. If local governments do not meet their specified responsibilities under the court-ordered Care Plans, the Court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

A framework that requires community engagement and input

This is a framework that requires deep engagement with the community to ensure that it is built with Californians and not for them as we move urgently to respond to the humanitarian crisis in our midst. In the coming weeks, we intend to engage a broad set of stakeholders to further build this framework out and ensure it can deliver meaningful results for some of our most vulnerable neighbors.

> We call on organizations and individuals alike to engage with us by providing written feedback that can be sent to us at **BehavioralHealthTaskForce@chhs.ca.gov.**

Pathway through the CARE Court



Referral

Individual with untreated schizophrenia spectrum or other psychotic disorder who lacks medical decision-making capacity may be referred to the court by a family member, behavioral health provider, first responder, or other approved party to provide care and prevent institutionalization.

Clinical Evaluation

The civil court orders a clinical evaluation and appoints public defender and Supporter. Court reviews the clinical evaluation and, if the individual meets the criteria, the court orders the development of a Care Plan.

Care Plan

Care Plan is developed by county behavioral health, participant and Supporter including behavioral health treatment, stabilization medication, and a housing plan. Court reviews and adopts the Care Plan with both the individual and county behavioral health as party to the court order for up to 12 months.

Support

County behavioral health care team, with participant, and Supporter, begin treatment and regularly review and update Care Plan, as needed, as well as a Mental Health Advance Directive for any future crises. Court provides accountability with status hearings, for up to a second 12 months, as needed.

Success

Successful completion and graduation by the Court. Participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery. Mental Health Advance Directive in place for any future crises.

VENTURA COUNTY BEHAVIORAL HEALTH

Clients Served

Open episodes in February 2022 with billing activity in prior 12 months

As of 3/3/2022

All VCBH	VCBH Treatment Programs
SUS - County & Contractor	County & Contractor
MH Adult - County & Contractor	Includes outpatient and residential
MH Y&F - County & Contractor	
VCBH STAR	
Adult Crisis	

**VCBH enrolled clients only

	VCBH Program Group							
	All VCBH	**SUS**	**MH Adult**	**MH Youth and Family**	**VCBH STAR**	**VCBH Crisis**	**CSU****	**IPU****
Total Clients With Open Episode	**11,436**	**1,141**	**5,663**	**4,071**	**783**	**688**	**10**	**36**

**VCBH enrolled clients only

Total Clients With Open Episode	**VCBH Program Group**							
Age Group *	**All VCBH**	**SUS**	**MH Adult**	**MH Youth and Family**	**VCBH STAR**	**VCBH Crisis**	**CSU****	**IPU****
0-15	2,894	13		2,717	259	54		
16-25	2,238	186	762	1,194	194	137	1	6
26-59	5,026	885	3,793	160	297	377	8	24
60+	1,278	57	1,108		33	120	1	6
Grand Total	**11,436**	**1,141**	**5,663**	**4,071**	**783**	**688**	**10**	**36**

**VCBH enrolled clients only

Total Clients With Open Episode	**VCBH Program Group**							
Preferred Language	**All VCBH**	**SUS**	**MH Adult**	**MH Youth and Family**	**VCBH STAR**	**VCBH Crisis**	**CSU****	**IPU****
English	9,844	1,066	4,923	3,388	609	627	10	32
Spanish	1,173	60	558	509	81	29		1
Mixteco	18	1	2	15	1			
Other	93	4	68	17	3	6		2
Unknown / Not Reported	308	10	112	142	89	26		1
Grand Total	**11,436**	**1,141**	**5,663**	**4,071**	**783**	**688**	**10**	**36**

**VCBH enrolled clients only

Total Clients With Open Episode	VCBH Program Group							
Ethnicity	All VCBH	SUS	MH Adult	MH Youth and Family	VCBH STAR	VCBH Crisis	CSU**	IPU**
Latinx	5,882	601	2,560	2,575	449	187	2	14
Non-Latinx	4,105	442	2,648	862	198	261	7	19
Unknown / Not Reported	1,449	98	455	634	136	240	1	3
Grand Total	**11,436**	**1,141**	**5,663**	**4,071**	**783**	**688**	**10**	**36**

**VCBH enrolled clients only

Total Clients Served At Each Location ***	VCBH Program Group							
Program Service Location	All VCBH	SUS	MH Adult	MH Youth and Family	VCBH STAR	VCBH Crisis	CSU**	IPU**
CAMARILLO	485		93	392				
FILLMORE	144	30		114				
MOORPARK	10			10				
OXNARD	6,191	789	2,579	1,870	783	688		
SANTA PAULA	785		520	265				
SIMI VALLEY	1,254	83	718	472				
THOUSAND OAKS	1,208	42	848	328				
VENTURA	2,139	59	1,104	995			10	36
Outside Ventura County (Contractor)	315	293	23					
Grand Total	**12,531**	**1,296**	**5,885**	**4,446**	**783**	**688**	**10**	**36**

*** Clients may be counted under multiple locations

VENTURA COUNTY BEHAVIORAL HEALTH

Clients Served

Open episodes in February 2022 with billing activity in prior 12 months

As of 3/3/2022

All VCBH	VCBH Treatment Programs
SUS - County & Contractor	County & Contractor
MH Adult - County & Contractor	Includes outpatient and residential
MH Y&F - County & Contractor	
VCBH STAR	
Adult Crisis	

**VCBH enrolled clients

Total Clients With Open Episode	VCBH Program Group							
Residence Region - City	All VCBH	SUS	MH Adult	MH Youth and Family	VCBH STAR	VCBH Crisis	CSU**	IPU**
Conejo Valley	**972**	**85**	**524**	**258**	**78**	**100**	**1**	
Conejo Valley-Newbury Park	241	18	129	59	17	36		
Conejo Valley-Oak Park	31	3	7	19	2	2		
Conejo Valley-Thousand Oaks	644	60	356	166	55	59	1	
Conejo Valley-Westlake Village	56	4	32	14	4	3		
Moorpark	**359**	**23**	**132**	**190**	**24**	**18**		**1**
Moorpark	359	23	132	190	24	18		1
Ojai	**226**	**31**	**108**	**65**	**15**	**23**		
Ojai	184	26	89	50	10	21		
Ojai-Oak View	42	5	19	15	5	2		
Oxnard Plains	**5,163**	**502**	**2,527**	**1,922**	**367**	**279**	**6**	**19**
Oxnard Plains-Camarillo	862	72	435	272	38	106	1	5
Oxnard Plains-Oxnard	3,931	396	1,920	1,507	299	148	5	14
Oxnard Plains-Port Hueneme	355	34	162	140	28	24		
Oxnard Plains-Somis	15		10	3	2	1		
Santa Clara Valley	**1,118**	**76**	**471**	**533**	**82**	**43**		**3**
Santa Clara Valley-Fillmore	322	25	134	152	23	12		1
Santa Clara Valley-Piru	45	5	13	25	5	4		
Santa Clara Valley-Santa Paula	751	46	324	356	54	27		2
Simi Valley	**1,265**	**137**	**625**	**438**	**56**	**92**	**1**	**2**
Simi Valley	1,265	137	625	438	56	92	1	2
Ventura	**2,021**	**243**	**1,114**	**574**	**153**	**119**	**2**	**9**
Ventura	2,021	243	1,114	574	153	119	2	9
Not Reported	**312**	**44**	**162**	**91**	**8**	**14**		**2**
Not Reported	312	44	162	91	8	14		2
Grand Total	**11,436**	**1,141**	**5,663**	**4,071**	**783**	**688**	**10**	**36**

Notes:

Residence cities do not reflect client service location.

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health Plan

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family-member driven, recovery oriented, culturally and linguistically responsive, and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

For information, you may contact the following email address or telephone number:
DataNotebook@CMHPC.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA 95899-7413

California Behavioral Health Planning Council

Advocacy • Evaluation • Inclusion

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the CBHPC. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Council staff to create an annual report to inform policy makers, stakeholders and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on the county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

The 2021 Data Notebook is focusing on racial/ethnic inequities in behavioral health. This topic comprises only part of the Data Notebook. We also have developed a section (Part I) with questions that are addressed each year to help us detect any trends. Monitoring these trends will assist in identification of unmet needs or gaps in services which may occur due to changes in population, resources available, or public policy.

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health programs, needs, and services. This information is used in the Planning Council's advocacy to the legislature and for input to the state mental health

block grant application to SAMHSA[2].

[1]W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

[2]SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services and Substance Use Disorder Treatment. Similar data are analyzed each year to evaluate county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.

130 out-of-county youth were placed in Ventura County

In addition, members of the Planning Council would like to examine some county-level data that are not readily available online and for which there is no other publicly-accessible source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting these data will help us analyze aspects of the behavioral health system that are not currently tracked.

Please answer these questions using information for fiscal year (FY) 2020-2021 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.'

Adult Residential Care

There is little public data available about who is residing in licensed facilities on the website of the Community Care Licensing Division at the CA Department of Social Services. This makes it difficult to determine how many of the licensed Adult Residential Care Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires the collection of data from licensed operators about how many residents have SMI and whether these facilities have services these clients need to support their recovery or transition to other housing.

The Planning Council would like to know about the ARFs and Institutions for Mental Diseases (IMDs)[3] located in your county to serve individuals with SMI, and

how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs.

[3]Institution for Mental Diseases (IMD) List:
https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx

* 1. Please identify your County / Local Board or Commission.

Ventura County Behavioral Health Advisory Board

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?

405

3. What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

88,593

4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

Estimate: 250 individuals with unmet needs

5. Does your county have any "Institutions for Mental Disease" (IMDs)?

- ( ) No
- (X) Yes (If Yes, how many IMDs?)

One in-county IMD

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-County	381
Out-of-County	147

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

11,093 bed days.

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Homelessness: Your County's Programs and Services

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that approximately only 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. While the Council does not endorse the idea that homelessness is caused by mental illness nor that the public behavioral health system is responsible to fix homelessness, financially or otherwise, we know that recovery happens when an individual has a safe, stable place to live.

The past year has been like no other we have seen in recent history. We understand that the public behavioral health system has had to drastically change how it does business and possibly halt a number of activities that may have been in the works for implementation this year. That said, we are interested in what types of actions counties may be taking to assist individuals who are homeless and have serious mental illness and/or a substance use disorder.

8. During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)

- [X] Emergency Shelter
- [ ] Temporary Housing
- [X] Transitional Housing
- [X] Housing/Motel Vouchers
- [X] Supportive Housing
- [X] Safe Parking Lots
- [X] Rapid re-housing
- [X] Adult Residential Care Patch/Subsidy
- [X] Other (please specify)

Project Room Key: administered by County CEO's office

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Child Welfare Services: Foster Children in Certain Types of Congregate Care

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receives foster children but a small number of the children need a higher level of care and are placed in a 'Group Home'. California is striving to move away from the use of long-term group homes, and prefers to place all youth in family settings, if possible. California has revised the treatment facilities for children whose needs cannot be safely met initially in a family setting. Group homes are to be transitioned into a new facility type called Short-Term Residential Treatment Program (STRTP). STRTPs will provide short-term, specialized, and intensive treatment individualized to the need of each child in placement.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment.

9. Do you think your county is doing enough to serve the children/youth in group care?

- ( ) Yes
- (X) No (If No, what is your recommendation? Please list or describe briefly)

Better paid and better trained staff. Presently there is frequent staff turnover inhibiting continuity of services/treatment.

Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Type te

10. Has your county received any children needing "group home" level of care from another county?

- ○ No
- ☒ Yes (If Yes, how many?)

130 out-of-county youth were placed in Ventura County

11. Has your county placed any children needing "group home" level of care into another county?

- ○ No
- ☒ Yes (If Yes, how many?)

13 Ventura County youth were placed outside of Ventura County

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Part II: Racial/Ethnic Inequities in Behavioral Health

Background and Context

California is one of the most culturally diverse states in the nation regarding race, ethnicity, and language. This diversity is one of the state's greatest assets, but it also comes with a need to provide services in ways that are culturally relevant and respectful of these diverse communities. Health disparities by race and ethnicity are well documented, and there are prominent inequities in behavioral health outcomes and access to services. The state has a responsibility to address these disparities and work towards a mental health system that serves California's cultural and linguistic diversity.

The 2014 Data Notebook touched on some of these issues in a section titled "Access by Unserved and Under-Served Communities." Using data from the External Quality Review Organization (EQRO), the number of individuals eligible for Medi-Cal in the county was compared to the number who were served in county Specialty Mental Health programs in two charts, broken down by race/ethnicity. The counties were then asked 3 questions.

1. Is there a big difference between the race/ethnicity breakdowns on the two charts? Do you feel that the cultural group(s) that needs services in your county is receiving services?

2. What outreach efforts are being made to reach underserved groups in your community?

3. Do you have suggestions for improving outreach to and/or programs for underserved groups?

Since 2014, awareness of inequities in behavioral health has continued to increase. In 2017, Governor Jerry Brown signed AB 470 (Arambula) into law, which requires the tracking and evaluation of Medi-Cal specialty mental health services with the goal of reducing mental health disparities. The California Pan Ethnic Health Network (CPHEN) developed an Advisory Workgroup in 2018 to provide recommendations for the implementation of AB 470. The Department of Health Care Services published the first report of the data in 2019, with an update in 2020. The California Health Care Foundation (CHCF) and CPHEN released a report in November 2020 with analysis of that data, highlighting some of the findings that the data provides while also providing recommendations for additional

measures focused on quality of care and outcomes. It also called for continued stakeholder engagement to ensure that "performance and disparity reduction measures reflect consumer needs."

This is just one example of the efforts being made to address behavioral health inequities; there is much more work to be done. The CBHPC Equity Statement acknowledges the impact of social injustice on the behavioral health system that leads to health inequities, and "supports California in achieving the goals to reduce disparities, rebuild the trust lost from communities that have been historically under/inappropriately served and eliminate social injustice and racial inequities." As part of the effort to put this into action, the 2021 Data Notebook is returning to this timely topic.

* 12. Based on the data provided for your county, please rate the **access**, **engagement**, and median time to stepdown services for each of the following racial/ethnic groups in your county.

	Access (**At least one** mental health services visit in a single fiscal year)	Engagement (**Five or more** mental health services visits in a single fiscal year)
Alaskan Native / American Indian	Good/fair	Good/fair
Asian or Pacific Islander	Fair/poor	Fair/poor
Black	Good/fair	Good/fair
Hispanic	Fair	Poor
Other		
White	Fair	Fair/poor

* 13. Which outreach, community engagement, and/or education methods are being used to reach and serve the following racial/ethnic groups in your county? (Please check all that apply. If a given method is not utilized for any group, please select "N/A")

	Alaskan Native / American Indian	Asian or Pacific Islander	Black	Hispanic	Other	White	N/A
Outreach at local community venues and events	X	X	X	X	X	X	

	Alaskan Native / American Indian	Asian or Pacific Islander	Black	Hispanic	Other	White	N/A
House visits to underserved individuals/communities	X	X	X	X	X	X	
Telehealth services to increase access and engagement	X	X	X	X	X	X	
Community stakeholder meetings/events	X	X	X	X	X	X	
Written materials translated into multiple languages		X		X			
Live or virtual (real-time) interpretation services		X		X		X	
Educational classes, workshops, or videos	X	X	X	X	X	X	
Providing food/drink at meetings and events							X
Providing reimbursement or stipends for involvement							
Providing transportation to and from services	X	X	X	X	X	X	X

Other (please describe)

Engaging faith-based organizations; collaborating wtih municipal governments/agencies (i.e. Parks & Recreation); school districts; law enforcement; and Public Defender's Office.

*** 14. Which of the following groups are represented on your mental health board/commission? (Please select all that apply.)**

- [ ] Alaskan Native / American Indian
- [ ] Asian or Pacific Islander
- [X] Black
- [X] Hispanic
- [X] White
- [X] Other race/ethnicity
- [X] Older adults (65+ years)
- [ ] Transition-age youth (16-24 years)

Hours of service; lack of childare; lack of integrated treatment for individu with co-occuring disorders and/or dual diagnosis individuals; lack of coordination between treatment systems.

*** 15. Which of the following steps have been taken to develop a culturally diverse behavioral health work force in your county? (Please check all that apply.)**

- [X] Tailoring recruitment efforts (re: professional outreach and job ads) to applicants who are representative of the racial/ethnic populations in your county
- [X] Utilizing behavioral health workforce pipeline programs that value cultural/linguistic diversity among applicants
- [X] Actively cultivating a culturally inclusive workplace environment in which racial/ethnic minority staff are engaged
- [X] Conducting listening sessions or other methods for staff to provide feedback on workplace environment and hiring/promoting practices
- [X] Providing professional development opportunities such as mentorship or continued education and training for behavioral health staff and providers
- [X] Other (please specify)

Volunteer/shadow opportunities; engaging schools, vocational schools, community colleges, colleges and universities.

- [ ] None of the above

*** 16. Does your county provide cultural proficiency training for behavioral health staff and providers?**

- ( ) No
- (X) Yes (please describe)

Cultural Competency: Juvenile Justice with Hispanic and Latino Youth; LGBTQ RISE training; Cultural Competency: Start Again, Not Over: Cultural Competency, Health, Mental Health & Spirituality; Cultural Competency - Reflections: What Do We Know About Us?; Cultural Competency - Building a Culturally Informed Framework for the Delivery of Behavioral Health Services with Clas (4 trainings); LGBTQ Rise training; Cultural Diversity and Sensitivity with Dr. Stroud; Cultural Sensitivity and Diversity.

*** 17. Which of the following does your county have difficulty with in regard to providing culturally responsive and accessible mental health services? (Please select all that apply.)**

- [X] Employing culturally diverse staff and providers
- [X] Retaining culturally diverse staff and providers
- [ ] Translating written materials
- [ ] Providing live/virtual interpretation services
- [ ] Providing cultural proficiency training for staff and providers
- [ ] Outreach to racial/ethnic minority communities
- [X] Other (please specify)

Growing efforts to improve culturally responsive and accessible mental health services.

*** 18. What barriers to accessing mental health services do individuals from underserved communities face in your county? (Please select all that apply.)**

- [X] Language barriers
- [X] Lack of culturally diverse/representative staff providers
- [X] Distrust of mental health services
- [X] Community stigma
- [X] Lack of information or awareness of services
- [X] Difficulty securing transportation to or from services
- [X] Difficulty accessing telehealth services
- [X] Other (please specify)

Hours of service; lack of childcare; lack of integrated treatment for individuals with co-occurring disorders and/or dual diagnosis individuals; lack of coordination between treatment systems.

19. Do you feel that the COVID-19 pandemic has increased behavioral health disparities for any of the following groups? (Please select all that apply.)

- [X] Alaskan Native / American Indian
- [X] Asian or Pacific Islander
- [X] Black
- [X] Hispanic
- [ ] White
- [ ] Other race/ethnicity
- [X] Older adults (65+)
- [X] Transition-age youth (16-21)
- [X] Children (under 16)
- [ ] None of the above

*** 20. Please rate the impact of the use of telehealth services during Covid-19 for the following groups regarding access and utilization of behavioral health services.**

	Very Positive	Somewhat Positive	Neutral	Somewhat Negative	Very Negative
Alaskan Native / American Indian	○	X	○	○	○
Asian or Pacific Islander	X	○	○	○	○
Black	X	○	○	○	○
Hispanic	○	X	○	○	○
Other race/ethnicity	X	○	○	○	○
White	X	○	○	○	○

*** 21. Which providers or services have been employed, utilized, or collaborated with to serve the following racial/ethnic populations in your county? (Please select all that apply. If a given provider or service is not utilized for any group, please select "N/A")**

	Alaskan Native / American Indian	Asian or Pacific Islander	Black	Hispanic	Other	White	N/A
Community Health Workers / *Promotoras*	X	X	X	X	X	X	☐
Community-accepted first responders	X	X	X	X	X	X	☐
Peer support specialists	☐	☐	☐	☐	☐	☐	☐
SUD providers	X	X	X	X	X	X	☐
Community-based organizations	X	X	X	X	X	X	☐
Local tribal nations / native communities	☐	☐	☐	X	☐	☐	☐

	Alaskan Native / American Indian	Asian or Pacific Islander	Black	Hispanic	Other	White	N/A
Homeless services	X	X	X	X	X	X	
Local K-12 schools	X	X	X	X	X	X	
Higher education institutions	X	X	X	X	X	X	
Domestic violence programs	X	X	X	X	X	X	
Immigration services				X			
Sport/athletic teams or organizations	X	X	X	X	X	X	
Grocery stores or food pantries	X	X	X	X	X	X	

Type text here

Other (please specify)

Laundry mats and churches.

22. Do you have suggestions for improving outreach to and/or programs for underserved groups?

Improve opportunities for participating in decision making at all stages of program and service planning, delivery and evaluation.

CBHPC 2021 Data Notebook for California Behavioral Health Boards and Commissions

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

23. What process was used to complete this Data Notebook? (please select all that apply)

- [X] MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions
- [X] MH Board completed majority of the Data Notebook
- [X] Data Notebook placed on Agenda and discussed at Board meeting
- [X] MH board work group or temporary ad hoc committee worked on it
- [X] MH board partnered with county staff or director
- [X] MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function
- [ ] Other (please specify)

24. Does your board have designated staff to support your activities?

- ( ) No
- (X) Yes (if Yes, please provide their job classification)

Management Assistant, Behavorial Health Administration

25. Please provide contact information for this staff member or board liaison.

Name	Victoria Poliquin
County	Ventura
Email Address	bhabadmin@ventura.org
Phone Number	805-981-1881

26. Please provide contact information for your Board's presiding officer (Chair, etc.)

Name	Michael Rodríguez
County	Ventura
Email Address	Michael.Rodriguez@ventura.org
Phone Number	805-654-3199

27. Do you have any feedback or recommendations to improve the Data Notebook for next year?

Greater lead time before due date.

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☐ Local Mental Health Board approval Approval Date: March 21,2022
☐ Completed 30 day public comment period Comment Period: 2/18/22-3/21/22
☐ BOS approval date Approval Date: March 29th or _April 5th If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: _____ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: __May 26, 2022_____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

County Name: Ventura County

Date submitted: March 22, 2022

Project Title: Managing Assets for Security and Health (MASH) Senior Supports for Housing Stability

Total amount requested: $966,706

Duration of project: 5 years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports." As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☒ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☒ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

The issue of seniors at risk of or currently experiencing homelessness has been highlighted over and over in recent years. A report published by the University of Pennsylvania analyzed historical records of shelter admissions in three of the nation's largest cities projecting that in the next 10 years, the number of elderly people experiencing homelessness will nearly triple as the baby boomer's generation continue to age[1]. Findings were published before the effect of the pandemic could be taken into consideration. Prior to the pandemic, multiple headlines have warned of the impending crisis or the silver tsunami thundering toward social service providers[2]. While multiple reports have warned of the impending crisis, senior support services agencies argue the emergency is already here. Another recent study from University of California San Francisco expert Dr. Margot Kushel found "people over 50 now account for half of unhoused adults – a four-fold increase since 1990 when 11% of homeless adults were over 50. Older people already on the financial edge after decades of working low-wage jobs and with little or no savings or retirement income can be quickly de-stabilized by a rent increase, or injury or death of a partner or caregiver." Many of the above conditions are common occurrences for individuals in the later stages of life. Kushel also found disturbingly, that nearly half of unhoused older people didn't experience their first episode of homelessness until after age 50[3].

In Ventura County rent increases have been steadily on the rise for the past few years. A complicating factor is the County's geography and the voter approved land use agreements. Much of the County is dedicated to the vital agricultural industry, open spaces initiatives and protected state and national resources that include rivers, beaches, and forest areas. As a result, housing, like many other areas in the state, has become scarce. The pandemic has worsened the situation, housing prices have soared, and

[1] Emerging-Crisis-of-Aged-Homelessness-1.pdf (upenn.edu)
[2] Elderly and Homeless: America's Next Housing Crisis - The New York Times (nytimes.com)
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250535/

rentals remain scarce. Moreover, rents surged in 2021 by 10.9% in the last fiscal year, more than twice the normal rate. According to the National Low-Income Housing Coalition, a person working minimum wage and living in a modest one bedroom would have to work 89 hours per week in order to afford the $1,615 dollars per month in rent[4]. The chances of finding a fair market price rental in the area is equally as challenging with a vacancy rate down to an average of 1.37% in 2021[5]. Social Security Income averages $932 per month, falling far short of being enough for even a studio apartment in the area.

Senior service providers have noticed an increase in requests for services and the need for financial counseling for low-income seniors who never planned on rents or other expenses escalating so quickly. "I regularly speak to seniors who have anywhere from a few years to a few months before their expenses will exceed their incomes. They freeze with anxiety and sink into despair, seeing the cliff that's coming and not knowing what to do about it." -Executive Director of Volunteer CAREGIVERS of Ventura County. Her sentiments were confirmed by the last Community Program Planning (CPP) Process. Innovation community program submissions included 28 program ideas and the support for seniors at risk of losing housing came in as the second most voted for program after mobile mental health.

PROPOSED PROJECT

Project Goal: To provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions.

Assumptions of Program Approach: By assigning and monitoring volunteers to work with homebound seniors, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan to include essential services and concrete resources as needed. The participants will be able to explore multiple solutions to their housing situation over time, increasing the chances for success in a new placement.

Key Intervention: Matching trained specialty peer volunteers with homebound seniors who can help identify and work with those seniors who are in jeopardy of losing their current housing.

Volunteer CAREGIVERS of Ventura County is a small non-profit agency that recruits volunteers to support home bound elderly. Participants are predominantly women (80%) who live on fixed/limited

[4]Fair Market Rent Documentation System, HUD
https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2022_code/2022summary.odn

[5]Wilson, Kathleen "'Historically tight' apartment market pinches local tenants as rent hikes surge". *VC Star*, November 7, 2021 https://www.vcstar.com/story/news/2021/11/07/apartments-for-rent-nearby-unlikely-as-rental-market-grips-tenants-rising-costs-few-vacancies/8558423002/

incomes and are frequently medically fragile and/or disabled. Volunteer support, also comprised mostly (80%) of women over 60, is at no cost to the senior and may range from friendly visitation, transportation for medical appointments, shopping for groceries and medical supplies, regular "warm line" phone calls, and support from supervised volunteers — mostly peers who may do cooking, minor house cleaning or yard work. A number of these seniors served (estimated at 10% or more) are on the verge of becoming homeless. These seniors are often physically and emotionally fragile (many are wheelchair bound, experiencing loneliness and confusion) and are experiencing memory loss, or the beginning stages of dementia and Alzheimer's disease. To compound their situation, their families are frequently unable to assist them and/or they live in another state. Local housing authorities have in some cases years-long waiting lists. The CAREGIVERS organization identified a set of previously unprovided services and a focused set of highly trained volunteers to address this unique subset of home bound seniors, and to re-energize the "Home Share" model that has been used in other parts of the County for this vulnerable population of potentially homeless seniors.

The proposed program entitled MASH, an acronym for Managing Assets for Security and Health, will provide multiple vital supports for seniors at risk of homelessness. The general program will consist of three phases and start with a four-step assessment. MASH directly addresses not only the County's current needs, but also our anticipated longer-term needs for affordable, safe, and stable housing for our seniors.

Phase I: Outreach will be made to all seniors already enrolled or referred to the Volunteer CAREGIVERS of Ventura County organization who are at risk of losing their current housing. Eligible seniors will be enrolled in the volunteer matching and begin a process of relationship building to expand the participant's support system. The volunteer will help the participant build a Customized Housing Budget and Stabilization (CHBS) plan based on the following four components: (1) to assess a senior's mental, physical, and financial health, (2) to review their challenges and opportunities, (3) to explore their options and empower their choices, and (4) to implement a plan that ensures security in appropriate housing.

The CHBS plan will also determine which tier the participant falls into:

Tier 1: Self-resolve; housing coaching or education only

Tier 2: On site modifications for aging in place, benefit enrollment, reverse mortgages, or other financial management goals with CPA oversight

Tier 3: Rapid re-housing, light rental subsidy, or home share with intensive case management

Tier 4: Housing placement and intensive case management

Once a plan has been agreed to by the participant, the MASH program volunteers would offer a menu of services customized per the CHBS plan. Essential services would include external clinical support sessions, financial education training, family process meetings, light case management, homemaking

services (chores, cleaning), non-medical transportation, independent living skills (life coaching and money management), or other general support services. Essential services would be offered and customized regardless of clients Tier placement. All clients would have access to clinical support by the organization's volunteer LCSW and MSW students at the beginning, and later with a subcontracted clinical services organization as needed. Reports of depression and anxiety have been high, and short-term family counseling has been identified as a critical service expected to be expanded, given the potential of some clients needing to move in with or have a family member move in to assist with care or financial support.

Phase II: Clients placed in Tiers 2-4 will have a wider variety of resources to access. These are the highest risk individuals that the organization currently cannot support. This Innovative service will begin with a test phase serving 4 clients with the following concrete services as needed:

*_Immediate support_ resources to ensure the individual does not become homeless. (e.g., financial assistance, temporary shelter, rapid rehousing, etc.)

*_Age in place supports_ (e.g., include family network to move in if viable, handicap accessible or other home modifications, home share, reverse mortgages, utilities, or other bills requiring backpay, etc.)

*_Moving Supports_ (e.g., secure placement in new housing arrangement, first/last month securities, downsizing, light rental subsidy, etc.)

If the test clients are successful and would recommend the program to others, an additional 25-50 clients will be targeted for admission.

Phase III would consist of Graduation and After-Care for a period of 6-12 months. Intensive post-move support would include organizing the new space, learning a new neighborhood, processing the move, and resolving interpersonal issues with any new housemates-to-be provided by a counselor or a traditional CAREGIVERS volunteer support staff depending on the client's adjustment. This final phase may also include a 1:1 Match from the Building Bridges Intergenerational Program. Phase III ensures that program participants continue to receive support to ensure sustainability of services received while in program.

RESEARCH ON INN COMPONENT

There is general agreement in the field of gerontology that aging well includes both personal and environmental resources[6]. The CAREGIVERS national organization has been providing light personal

[6] Lawton, M. P. (1982). Competence, environmental press, and the adaptation of older people. In M. P. Lawton, P. G. Windley, & T. O. Byerts (Eds.), Aging and the environment: Theoretical approaches (pp. 33–59). Springer.
Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), The psychology of adult development and aging (pp. 619–674). American Psychological Association.

services though volunteer matches for nearly 40 years. The MASH program will be the first time combining several initiatives from sister agencies from across the nation (i.e., home shares and home modifications) and adding a housing fund with the specialized economic development team with advisement from professional financial services agency. A key strategy to improve housing affordability is to increase the availability of rental assistance. According to a recent article by Dr. Margot Kushel, only 1 in 4 households in America that meets the criteria for rental assistance receives it. Among older adults, that number increases to 1 in 3. Rental assistance is not an entitlement, and the various federal programs that provide affordable rental opportunities are not funded to meet the demand[7]. The MASH program will connect clients with any benefits the client may be eligible for and assist in finding locations that will accept tenants receiving rental assistance. In addition, rental assistance fund is being included in the budget as a stop gap measure for clients already past the point of being able to avoid homelessness without immediate assistance.

LEARNING GOALS/PROJECT AIMS

Change can be difficult for anyone but can be an exaggerated barrier for individuals who are disabled, cognitively impaired, or under financial duress. O top of these challenges, many of these clients have not had to think about moving for 20-40 years and have been living in the same places where they raised their families or lost their spouses. The MASH program is designed to offer individuals a partner in that process of identifying the need to make a change and then having the courage to make that life altering move. The following are the identified learning goals and questions to be addressed though the program.

1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?

2. How much does the program improve client's sense of security and safety?
   Aim 1: Living situation
   Aim 2: Fiscal situation

3. Does enrollment in the program reduce feelings of depression, anxiety, and isolation?

4. Does the program have an effect on enrolled clients' housing situation? As measured by:
   Aim 1: Prolonged ability to stay in current housing (Tier 1&2 clients only)
   Aim 2: Reduced evictions
   Aim 3: Stably housed 6-12 months post discharge (Tier 3&4 clients only)

[7] Kushel, Margot (2020) Homelessness Among Older Adults: An Emerging Crisis. Generations Journal Summer 2020 Homelessness, Older Adults, Poverty, Health (asaging.org)

EVALUATION OR LEARNING PLAN

The evaluation will use existing scales whenever possible and some that are under consideration are referenced below. The evaluator will work with CAREGIVERS and VCBH staff to finalize all proposed measures, data collection tools, and analysis plans to ensure both process and outcomes/impacts are assessed and reported on through the MASH program evaluation.

Learning Goal	Indicators	Measures under consideration
1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?	Increased wiliness to change living circumstances such as taking on a roommate, moving family in or with family, moving to a new location	The Transtheoretical Model (TTM) or Moving on Initiative developed by the Veterans Administration Homeless Services.
2. How much does the program improve a client's sense of security and safety?	Improvement in perceived security, safety, and health rating	Security & Safety Perception Tool (5-point agree–disagree scale Ranging from strongly agree (5) to disagree (1): An example item: "Considering my age, I am in good health" and "I try to maintain a healthy lifestyle."[8]
Aim 1: Living situation	Increase in feelings of security	Security & Safety Perception Tool. Example item: "I feel safe where I live".
Aim 2: Fiscal situation	Increase in feelings of security	Security & Safety Perception Tool. Example Item: "I have sufficient financial resources to stay where I am living," and "I have enough money to live my life the way I want" 8. Supplemental items will include items asking clients to rate their feelings regarding whether they have enough money to pay for their needs (e.g., relative to food, medical services, and daily expenses) on a 3-point scale ranging from enough (1) to not enough (3). Lastly, clients will be asked to rate how easy or difficult it is to pay their monthly bills (i.e., rated on

[8] Anat Toder Alon, Liad Bareket-Bojmel & Avichai Shuv-Ami (2021): The Relationship between Perception of Care, Sense of Security, and Subjective Psychological Well-Being among Older Adults Living in Sheltered Housing vs. Independent Housing in Israel, Journal of Aging and Environment, DOI: 10.1080/26892618.2021.2019867

		4-point scale, ranging from not at all difficult (1) to very difficult (4).[9]
3.Does enrollment in the program reduce feelings of depression, anxiety, and isolation?	Increases in overall mental health and well being	Three-item Scale of Life Satisfaction developed by Lumpkin and Hunt[10] Or Revised University of California Los Angeles Loneliness Scale (RULS-V3) Center for Epidemiological Studies Depression Scale (CES-D).
4.Does the program have an effect on enrolled clients housing situation? Measured by:	Enhancements in overall housing situation	Housing Stability Assessment (brief assessment to determine current/later in program overall housing situation) as measured by select items using Likert rating scale.
Aim 1: Prolonged ability to stay in current housing (Tier 1 & 2 clients only)	Months of stability increased as compared to initial assessment	Fiscal longevity assessment
Aim 2: Reduced moves, foreclosures or evictions	Fewer number of moves, foreclosures or evictions than predicted after CHBS assessment	Two items: "How many times have you moved in the last 6 months?" and "Did you experience any foreclosures or evictions in the last 6 months?"
Aim 3: Stably housed 6-12 months post discharge (Tier 3 & 4 clients only)	Number of months at the same address.	Number of changes of address requests and number of moves.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

The project includes target goals, evaluation support, bi-annual contract meetings, the support of VCBH department staff and an innovation Program Administrator to work with the contractor and ensure compliance with the project plan and deliverables.

[9] Kee-Lee Chou & Iris Chi (2001) Financial strain and depressive symptoms in Hong Kong elderly Chinese: The moderating or mediating effect of sense of control, Aging & Mental Health, 5:1, 23-30, DOI: 10.1080/13607860020020609

[10] Lumpkin, F. J., & Hunt, B. J. (1989). Mobility as influence on retail patronage behavior of the elderly: Testing conventional wisdom. Journal of the Academy of Marketing Science, 17(1), 1–12. https://doi.org/10.1007/BF02726348

COMMUNITY PROGRAM PLANNING

The COVID-19 pandemic has hindered the regular and in person CPP process for the Fiscal Year 20/21 planning process for available Innovation dollars. Ventura County has been building upon its community-wide Mental Health Needs Assessment that was completed for the current three-year plan (Fiscal Year 2020-2023). Results from that effort identified several vulnerable communities and challenges to the mental health services currently being provided in the community. To that end the County advertised for Innovation submissions as described below.

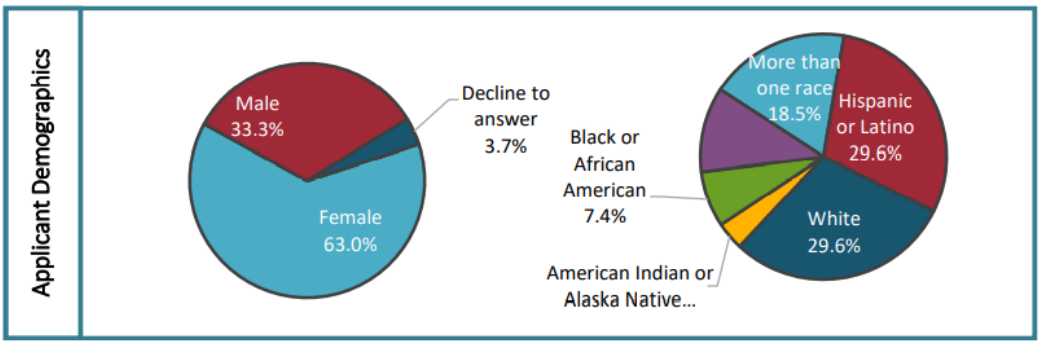
The current local priorities for mental health services are unserved or underserved populations in Ventura County such as: Latinx, African American, LGBTQ+, people who are homeless, people with co-occurring disorders (mental health and substance use), and people at risk of suicide.

Examples of the advertisements that were posted in local newspapers, through social media and internet advertisements are below:

An MHSA stakeholder planning committee was gathered and included individuals living with a serious mental illness, family members of individuals living with serious mental illness, Latinx, LGBTQ+, all geographic regions, genders, religious communities, and community-based organizations. The planning process resulted in 28 Innovation ideas that were submitted though the County website. Committee members had five days to assess the summary proposals and vote for their top three after a brief orientation to Innovation regulation requirements. Mobile Mental Health was the top choice by several votes and was approved in 2021. In second place was the Senior Supports for Housing project.

Results of the virtual CPP Innovation submission process are below. A total of 27 ideas were received through the website and one was submitted directly to the department. Applicants were not required

to answer all the demographic questions and could also click more than one answer so not all sections will add up to 100%.



MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration: CAREGIVERS is a community service provider and was chosen though a Community Planning Process that included individuals living with a serious mental illness, family members of individuals living with serious mental illness, Latinx, individuals who identified as LGBTQ+, all county geographic regions, genders, multiple religious communities, and other community-based organizations.

B) Cultural Competency: CAREGIVERS is committed to providing services, offering employment, and volunteer opportunities to all, without discriminating on the basis of age, gender, race, religion, sexual orientation, ethnicity, national origin or disability. The agency will work

closely with the Office of Equity and Diversity though the contracting process to ensure outreach and offering of services is equitable to all eligible participants.

C) Client-Driven: Clients are partners in their CHBS plans and must voluntarily sign off on any plans for housing changes or additional essential or concrete services.

D) Family-Driven: Families will be included in the process whenever viable though family meetings, group therapy, moving in with or having a participant move in with the family. Family members also will be included whenever possible before fiscal decisions impacting clients are made (e.g., perusing a reverse mortgage).

E) Wellness, Recovery, and Resilience-Focused: All services are designed to keep the participant in an environment that is safest for them physically and financially, allowing the client to live with dignity and security.

F) Integrated Service Experience for Clients and Families: CAREGIVERS already works closely with several agencies in the county and would continue these partnerships in order to keep as many options open for clients as possible examples include: VCBH, Jewish Family Services, Grey Law, Public Gradian, Adult Protective Services, Public Health, and the Area Agency on Aging.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

CAREGIVERS is committed to proving services, offering employment and volunteer opportunities to all, without discriminating on the basis of age, gender, race, religion, sexual orientation, ethnicity, national origin, or disability. Pairing of volunteer matches is based on geography, skill set and personal interests on which volunteers and care receivers can build a friendship. Using this 40-year tested model of service has resulted in relationships that have endured up to 20 years and enrollment with the organization for up to 36 years. Services and materials are provided in English and Spanish, and the organization is looking into additional cultural competency trainings.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep elements of the INN project without utilizing INN Funds following project completion.

CAREGIVERS has planned for sustainability with the assumption that this is a one-time grant. The proposed project budget reflects a primarily volunteer staffing base in accordance with the current business model. Learning collaboratives and planning efforts have been built into the grant to build awareness with the broader state and national CAREGIVERS association. The thinking is that with these broader networks, not exclusive to the CAREGIVERS organization, collaboration is ensured, and with successful implementation of the project, the MASH program can be modeled and maintained irrespective of Innovation funding.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

It is unknown at this point if the program will serve individuals with serious mental illness. The target population would primarily be for prevention services, however the program model has included individuals experiencing serious mental illness previously. If this does become the case, CAREGIVERS will work closely with the VCBH housing department staff to ensure supports are maintained for any clients living with serious mental illness at the conclusion of the five years.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?*

Each of the VCBH innovation programs have a dedicated webpage where updates get posted regularly. In addition, an Innovation summary page also exits where reports get posted on the Wellness Everyday website. In order to supplement these efforts, the program has built in three learning communities to help disseminate the projects findings.

B) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

At-risk homeless, prevention, seniors, housing stability, home-share

TIMELINE

A) *Specify the expected start date and end date of your INN Project*

B) *Specify the total timeframe (duration) of the INN Project*

C) *Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.*

Year 1		
Qtr 1-2	Infrastructure Development	Program planning, hiring, additional detail below.
Qtr 3-4	Program Launch	Project activities launch-additional details below Evaluation finalized.
Year 2		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Surveys distributed to enrolled clients. Annual update report is written and distributed.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Implementation with 2-4 test cases of Tier 3 & 4 clients. Baseline and initial surveys distributed/collected for enrolled clients.
Year 3		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Surveys distributed/collected for enrolled clients. Annual update report is written and distributed.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Surveys distributed/collected for enrolled clients. First Learning Community takes place.
Year 4		
Qtr 1-2	Program Activities	Ongoing program enrollment and engagement. Annual update report is written and distributed. Surveys distributed/collected for enrolled clients.
Qtr 3-4	Program Activities	Ongoing program enrollment and engagement. Second Learning Community takes place. Surveys distributed/collected for enrolled clients.
Year 5		
Qtr 1-2	Active Enrollment Ends	No additional clients will be enrolled after November of 2026. Annual update report is written and distributed. Surveys distributed/collected for enrolled clients.
Qtr 3-4	Evaluation and Program Wrap-Up Key Stakeholder Interviews	Key stakeholder interviews with clients, staff, and partner agencies. Programs wrap-up activities. Collect follow up surveys. Case closures and transition planning. Final Learning Community takes place.

Detailed Planning for Year One:

*Orientation of current staff and Board of Directors regarding VCBH approved Innovations Senior Housing Project initiative.

*Engage a Certified Senior Advisor to develop the MASH team recruit and contract with Certified Financial Planner (CFP) to serve as lead member of Economic Solutions team.

*Development of job description, recruitment, and training plan for MASH team of volunteers to support the housing initiative; includes protocols for consideration of optional income alternatives (re-fi or reverse mortgage of home, sell assets, explore employment options, etc.).

*Establish internal housing support initiatives workflow model/process, application, screening, enrollment, case planning and assignments.

*Develop management plan of potential resources, establish criteria for approvals (rent subsidy, utilities, temporary relocation, etc.).

*CSA Consultant will work with CAREGIVERS Volunteer Engagement Coordinator to identify and recruit volunteers with appropriate professional experience to participate in Economic Solutions Team.

*Development of external clinical support services.

* Recruit, train and assign social work intern.

*Identify key community partners; define role and inter-agency agreements.

*Develop an SOP and a workflow model that illustrates client pathway.

Marketing and Outreach

* Identification and initial meetings with community partners to assist in successful housing solutions. Continued meetings to negotiate interagency agreements and ongoing program coordination where necessary.

*Develop marketing plan for recruitment of MASH Volunteers, general volunteers.

*Develop a marketing plan to provide outreach to seniors who are currently enrolled or could be enrolled and participate in MASH.

*Engage the Economic Solutions team in the development of client satisfaction survey with VCBH and evaluation team.

*Selection, training, assignment and field supervision of a social work student intern who will work with seniors in need of assessment of their housing needs, relocation and their ongoing support directed toward stabilization.

*Identify additional non-profit partners who can supplement rental assistance and housing essentials, (e.g., Turning Point, St. Vincent de Paul, Jewish Federation)

*Identify professional services and resources necessary to provide project support to seniors served, (e.g., language translation, clinical services, transportation, etc.).

*Identification of moving assistance and time-limited shelter, (e.g., motels, assisted living solutions, city shelters).

*Work with VCBH on project website design and development of links to CAREGIVERS own website offering(s).

*Identification and outreach to local, state, and national programs addressing the issues and supports for homeless seniors.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

A 3% increase is planned per year per categories.

Program Staffing Costs
This project time and attention from following staff:
Executive Director (20 hours per month x 32.00 per hour= $44,172)
Volunteer Engagement Coordinator (40 hours per month x 17.50 per hours= $49,075)
Administrative Assistant (12 hours per month x 15.00 per hour= $32,460)
Cost of living increase 3% per year
MSW Intern (1040 hours): $93,600
Payroll Taxes and Benefits: $37,057

A 3% increase is planned per year

Total personnel: $237,364

PROFESSIONAL SERVICES $303,875
A 3% increase is planned per year per categories.

1) Certified Senior Advisor/Financial Planner Contract(s): $145,000

   Engagement of CSA/CFP(s) to serve as lead team members of MASH teams providing mentoring, individual and group consultation to seniors and volunteer team members on client financial planning needs.
2) Clinical Services Contract(s): $109,375 Basic clinical services are projected to be subcontracted with local clinical agencies for more immediate response for staff consultation, individual and group clinical treatment services. Amount based on $65 per hour
3) Field Supervision of graduate student(s) by an MSW for a total of 96 hrs. @ $25 per hr. = $12,500
4) Language Interpretation Services: $12,500
5) Staff Consultation and Training: $25,000

Housing Gap Assistance: $127,251 Fund availability for temporary and time limited assistance to support 2 to 4 senior(s) served. Examples of expenditures might include and not be limited to:

*Motel expenses @ $80 per night = $40,185
* Rent assistance @ $100 per mo. = $20,836
* Deposit assistance @750 per senior = $22,325
* Utilities assistance @ $375 per senior = $11,160
* Funds for moving assistance @ $500 = $ 14,883
*Two Storage Units available as needed= $17,860

Operational Overhead Costs: $134,324
Project specific marketing costs and program supplies=$11,600.00

Learning Events and Conferences= $12,500
Overhead and indirect five percent (5%) $73,696

Total Contractor cost: $766,286

Evaluation Costs: $14,000 per year = $74,328

County Indirect Costs and 5% of direct Salaries and Benefits and other County Administrative cost: $126,092

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs						
OPERATING COSTS		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
5.	Direct Costs						
6.	Indirect Costs	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
7.	Total Operating Costs	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
NON-RECURRING COSTS (equipment, technology)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
11.	Direct Costs	$133,294	$140,249	$152,256	$164,618	$176,502	$766,919
12.	Indirect Costs	$9,827	$12,767	$14,712	$17,547	$18,844	$73,696
13.	Total Consultant Costs	$143,121	$153,016	$166,968	$182,165	$195,346	$840,614
OTHER EXPENDITURES (please explain in budget narrative)		FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
14.	Marketing						
15.	Learning Events and Conferences						
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)		$133,294	$140,249	$152,256	$164,618	$176,502	$766,919
Indirect Costs (add lines 3, 6 and 12 from above)		$31,295	$35,719	$39,757	$44,871	$48,146	$199,788
Non-recurring costs (line 10)							

Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET	$164,589	$175,968	$192,012	$209,489	$224,647	$966,706

BUDGET CONTEXT - 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 and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$21,468	$22,952	$25,045	$27,325	$29,302	$126,092
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	$4,313	$4,383	$4,702	$4,900	$5,100	$23,398
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$14,000	$14,420	$14,853	$15,298	$15,757	$74,328
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	$14,000	$14,420	$14,853	$15,298	$15,757	$74,328
TOTAL:							
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY and the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$164,589	$175,968	$192,012	$209,489	$224,647	$966,706
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	$164,589	$175,968	$192,012	$209,489	$224,647	$966,706
*If "Other funding" is included, please explain.							

Additional References

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Margot Kushel. Older Homeless Adults: Can We Do More? (2011, November 16) J Gen Intern Med. 27(1):5–6
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Ventura County Behavioral Health

Board Letter Summary of Contracts for February 2022

Board Date	Contractor	Amount	Term	Description
2/8/2022	All Languages Interpreting and Translating, Inc. (ALIT)	$165,000	July 1, 2021 through June 30, 2022	**Third Amendment to the Agreement for Interpreting and Translating Services with ALIT.** ALIT provides interpretation and translation services for VCBH in clinics, meetings, and community behavioral health forums. The use of interpreter services in clinics is critical to successful client outcomes because it helps to ensure that clients understand their treatment plan and how to safely administer medication. The use of interpreter services for meeting and community forums is critical for ensuring that the department can appropriately communicate to the public about the services that are available through VCBH and solicit public feedback on department initiatives. During the first five months of FY 2021-22, ALIT has billed $69,066 out of their total contract amount of $100,000. The FY 2021-22 Third Amendment with ALIT increases the contract amount from $100,000 to $165,000 (an increase of $65,000) in order to allow for an increase in services and costs due to the ongoing COVID-19 pandemic. This Agreement is funded with: (1) Short Doyle/Medi-Cal (SD/MC) Federal Financial Participation (FFP), (2) State General Fund, (3) 2011 Realignment (Trust N520-719C), (4) 1991 Realignment (Trust N510-717C), and (5) Mental Health Services Ac (MHSA) funding.
2/8/2022	Maxim Healthcare Services Holdings, Inc. (Maxim)	$1,350,000	July 1, 2021 through June 30, 2022	**Fifth Amendment to the Agreement for Medical Personnel Temporary Staffing and Recruiting Services with Maxim.** Maxim provides certified and/or licensed temporary staff to help fill vacant positions due to the difficulty in finding qualified and appropriately certified and/or licensed staff. This contractor is also used to help backfill existing positions due to unexpected leaves of absence. VCBH is taking appropriate steps to expedite its recruitments for qualified and appropriately certified and/or licensed staff, however, until staff can be hired and due to the impacts of the COVID-19 pandemic, VCBH is in need of temporary staff from Maxim. VCBH uses a variety of temporary staff from Maxim, including Registered Nurses, Mental Health Associates, and Licensed Marriage and Family Therapists. The current vacancy rate for VCBH is 18.5%. The FY 2021-22 Fifth Amendment to the Agreement increases the maximum contract amount from $600,000 to $1,350,000 to ensure proper service provision through fiscal year end. There are no other changes to the Agreement. This Agreement is funded with: (1) SD/MC FFP, (2) State General Fund, (3) 2011 Realignment (Trust N520-719C), (4) 1991 Realignment (Trust N510-717C), and (5) MHSA funding.
2/8/2022	California Mental Health Services Authority (CalMHSA)	$0	January 1, 2022 through December 31, 2022	**Participation Agreement with the CalMHSA for Peer Support Specialist Certification Services.** CalMHSA, a Joint Powers Authority created by California counties in 2009 to jointly develop and fund mental health services and education programs for members, is entering into participation agreements with interested counties to bring counties together to provide them with a Peer Support Specialist Certification program. The program is in response to Senate Bill 803, Beall (SB 803) which authorized the Department of Health Care Services (DHCS) to establish statewide requirements for the development of Medi-Cal certification programs for peer support specialists. DHCS released Behavioral Health Information Notice 21-041 establishing the statewide requirements and is working through CalMHSA to implement and administer all components of the Peer Support Specialist Certification Program. The Peer Support Specialist Certification Program is responsive to the needs of the Medi-Cal Specialty Mental Health and Drug Medi-Cal Organized Delivery System populations and is expected to go live by May 2022. There is no cost at this time to participate in the program, however, there could be future costs in subsequent phases of the project. Under the agreement, CalMHSA acts as the fiscal and administrative agent for the program. On behalf of participating counties, CalMHSA will implement and administer all components of the Peer Support Specialist Certification program, including: (1) required data collection and submission to DHCS, (2) certification of peers, (3) exam administration, (4) investigations, and (5) approval, auditing, and monitoring of training vendors. VCBH is expected to provide necessary and legally sanctioned assistance to CalMHSA in achieving the program goals and program performance. The initial term is considered a pilot phase, however, CalMHSA is seeking a contractual agreement with DHCS for continued funding beyond this initial pilot phase.
2/8/2022	Golden Hillmont House Mental Health Rehabilitation Center, LLC.	$0	July 1, 2021 through June 30, 2022	**Seventh Amendment to the Agreement for Medi-Cal Specialty Mental Health Rehabilitation Center (MHRC) Services with Golden Hillmont House MHRC, LLC.** Golden Hillmont House MHRC, LLC. operates the MHRC "Hillmont House," located in Camarillo, a 15-bed facility that provides housing and support for up to 18 months for individuals with severe and persistent mental illness to enable them to transition to independent or supported living arrangements. The program uses a psychosocial rehabilitation model that provides a balance of activities, education, vocational services, therapy, health, and socialization to support physical, psychological, and spiritual health. The Seventh Amendment to the Agreement with Golden Hillmont House MHRC, LLC. has made the following contract language revisions: (1) removed the requirement for the contractor to produce no less than the specified amount of SD/MC FFP revenue at 100% as this requirement does not apply to this program, (2) revised utilization review monitoring from monthly to quarterly as per revised VCBH policies and procedures, and (3) updated the contractor invoice submittal procedure. There is no change to the maximum contract amount.
2/8/2022	Golden Ventura CRT, LLC.	$0	July 1, 2021 through June 30, 2022	**Sixth Amendment to the Agreement for Medi-Cal Specialty Mental Health Care Short-term Crisis Residential Recovery Treatment (CRT) Services with Golden Ventura CRT, LLC.** Golden Ventura CRT, LLC. provides a short-term voluntary program for up to 15 adults experiencing increased psychiatric symptoms or a behavioral health crisis; an individual's length of stay does not exceed 90 days. The CRT facility's services are used by clients to avoid acute hospitalization or to assist clients in stepping down from an acute hospital stay. Treatment services include psychiatric care and medication management, individual and group therapy, life and coping skills training, peer support, substance abuse relapse prevention services, and recreational group activities. Services are designed to achieve psychiatric stabilization and community reintegration. The Sixth Amendment to the Agreement with Golden Ventura CRT, LLC., made the following contract language revisions: (1) removed the requirement for the contractor to produce no less than the specified amount of SD/MC FFP revenue at 100% as this requirement does not apply to this program, (2) revised utilization review monitoring from monthly to quarterly as per revised VCBH policies and procedures, and (3) updated the contractor invoice submittal procedure. There is no change to the maximum contract amount.