BEHAVIORAL HEALTH ADVISORY BOARD

General Meeting

Monday, October 17, 2022, 1:00 – 3:30 PM

Ventura County Behavioral Health (VCBH)

1911 Williams Drive, Training Room (first floor) • Oxnard, CA 93036

IN-PERSON & 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 September 19, 2022 Minutes – **ACTION** (Roll Call)

VI. Public Comments (3 min. per speaker)

VII. Presentation: Mixteco Indigena Community Organizing Project (MICOP) Living with Love Program – Victor Espinosa - Wellness Programs Director, Dulce Vargas - Project Manager, Leonides Aguilar - Promotora (20 min.)

VIII. Presentation: Rosenberg's Rules of Order – Jason Canger, Assistant County Counsel (15 min.)

IX. Presentation: Updated County Administrative Manual Highlights – Jason Canger, Assistant County Counsel (15 min.)

X. Chair Comments (10 min.)

XI. Director's Report – Scott Gilman (10 min.)

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

XIII. Secretary's Report / Announcements – Janis Gardner (10 min.)

XIV. BHAB Committee Reports (5 min each)

- A. Transitional Age Youth (TAY) Committee (August 17 meeting) – Elizabeth R. Stone, Chair
- B. Adult Services Committee (September 1 meeting) – Nancy Borchard and Gane Brooking, Co-Chairs
- C. Prevention Committee (September 13) – Janis Gardner, Chair
- D. Youth & Family Services Committee (October 12) – Kevin Clerici, Chair

XV. Old Business

- A. Needs Assessment – Status Update – Michael Rodriguez, Chair (5 min.)

Public comments on agenda items can be made prior to or during consideration of agenda items and are limited to 3 minutes per speaker. Public comment periods are limited to no more than (20) minutes total for all speakers. 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.

XVI. New Business

A. Public Hearing to End 30-day Public Comment Period on the California Mental Health Services Authority (CalMHSA) Innovation Semi-Statewide Electronic Health Record (EHR) Project – Michael Rodriguez, Chair - **ACTION** (Roll Call) (10 min.)

B. Appoint Chair of the Ombudsman Workgroup – Michael Rodriguez, Chair – (5 min.)

C. Freeway Overpass Suicides and Suicide Attempts Data Request – Michael Rodriguez, Chair – (10 min.)

D. 2022 Data Notebook BHAB Workgroup Update - Michael Rodriguez, Chair – (5 min.)

E. Presentation Requests

F. Recognition Award Recommendations

XVII. Contracts

Board of Supervisors Approved Agreements – September 13, 2022

1. Data Sharing Agreement with the California Health and Human Services Agency.

Board of Supervisors Approved Agreements – September 20, 2022

1. Standard Agreement with DHCS for the Provision of Specialty Mental Health Services to Medi-Cal Beneficiaries.
2. Eighth Amendment to the Agreement with DMG for the Provision of DMC-ODS Substance Use Disorder (SUD) Services.

XVIII. Public Comments (3 min. per speaker)

XIX. Adjourn

Next Meeting: Monday, November 21, 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 on agenda items can be made prior to or during consideration of agenda items and are limited to 3 minutes per speaker.** Public comment periods are limited to no more

than (20) minutes total for all speakers. The assigned timekeeper will track each public comment time. When your time is up, the timekeeper will interrupt to let you know that you have reached the 3-minute maximum. At the end of the three minutes, 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.

Living with Love: Reducing Mental Health Disparities for Migrant Indigenous Communities

Victor Espinosa, Irisela Contreras, Dulce Vargas
Mixteco Indigena Community Organizing Project (MICOP)

Co-Authors:
MICOP: Genevieve Flores-Haro, Teresa Santos, Leticia Galicia, Leonidez Aguilar
UCLA Kaiser Permanente Center for Health Equity: Alison Herrmann & Beth Glenn
Consultant Educator: Barbara Marquez

Migrant Indigenous Communities

- **Historically oppressed communities in Mexico**
  - Mental health and domestic violence awareness are non-existent
  - Governed by traditional norms and customs where strict gender roles, religious beliefs, and the patriarchal system is reinforced, affecting largely women who at a young age experience domestic abuse leading to mental health problems and isolation
- **DV is an ongoing concern in this population rooted in multiple risk factors**
  - Extreme poverty
  - Inequity
  - Lack of access to education
- **These practices and beliefs remain while in the U.S, AND barriers to report DV increases due to:**
  - Fear of deportation and family separation
  - Economic barriers
  - Unfamiliarity with the system
  - Language barriers

California Reducing Disparities Project

a culturally responsive mental health initiative

- Program of California DPH Office of Health Equity, Funded by Prop. 63, The Mental Health Services Act (MHSA)
- A culturally responsive mental health initiative
  - Funds **35** culturally responsive, innovative Implementation Pilot Projects (IPPs) across the state of California
  - **Five** population groups: African American; Latino/x; Asian and Pacific Islander; Native American; and LGBTQ+.
- Demonstrate the effectiveness of Community Defined Evidence-based Practices (CDEP) to reduce mental health disparities as opposed to traditionally funded mental health services based on Western clinical models.
- Validate through a rigorous evaluation
  - Local & Statewide Evaluation

CDPH California Department of PublicHealth

Living with Love (LwL)

Direct Prevention and Early Intervention mental health and domestic violence program for migrant indigenous women

- The Curriculum was **written** by MICOP's **Mexican indigenous Promotora** and Consultant Educator in response to the observed community's needs
- **Implemented** by two **migrant indigenous promotoras** (Zapotec and Mixtec origin)
- Eight-week bilingual (Spanish and Mixtec) program delivered throughout different community settings
- Group vs. 1-1 Approach
- Authentic grassroots outreach strategies
- Guided by a Community Advisory Board
- **UCLA Kaiser Permanente, Center for Health Equity**
  Subcontract from MICOP
  Technical Assistance and Consulting in evaluation

Community Mental Health Equity Project (CMHEP)

- **One-year supplemental funding from the California Department of Public Health, Office of Health Equity**
  - **Goal:** Expand the access to culturally and linguistically responsive behavioral health care in California.
- Allowed MICOP to provide, for the first time, professional mental health services for migrant indigenous communities, in collaboration with a local mental health agency
  - 12-free individual therapy sessions
  - Must participate in LwL first (reducing the stigma of mental health)

STUDY DESIGN & FINDINGS

- Mixed-methods, quasi-experimental, pre/post design
  - Surveys at 3 Time-Points
    - Start of Program, End of Program, (2-3 Months Post-Program)
  - Focus Groups (or Interviews)
    - 2-3 Months Post-Program
- Participation & Retention
  - Baseline surveys = 210
  - Follow-up surveys = 168
  - 2-3 Month Follow-Up Survey and Focus Group or Interview (n=75)

Table 1. Baseline Characteristics of Evaluable Participants

Characteristic	Overall N = 168[1]	Cohort (Group vs 1:1) 1:1 N = 39[1]	Group N = 129[1]	p-value[2]
		N(%); Mean(SD)		
Demographics				
Age	39 (11)	37 (10)	39 (11)	.154
Missing Values	4	0	4	
Years Lived in US	16 (9)	14 (8)	16 (10)	.264
Missing Values	7	0	7	
Marital Status (Married or Living w/ Partner)	109 (66%)	15 (38%)	94 (75%)	**<.001**
Missing Values	3	0	3	
Household size (number of children @ home + number of adults @ home + participant)	6.51 (2.44)	6.23 (2.51)	6.60 (2.43)	.430
Missing Values	8	0	8	
Language				.285
Spanish Only	64 (39%)	13 (33%)	51 (40%)	
Mixteco Only	44 (27%)	12 (31%)	32 (25%)	
Spanish + Other	40 (24%)	7 (18%)	33 (26%)	
Any English	18(11%)	7 (18%)	11(8.7%)	
Missing Values	2	0	2	
Domestic Violence Variables				
Knowledge	4.86 (1.75)	5.08 (1.06)	4.79 (1.91)	.233
Consequences	4.99 (1.76)	5.38 (1.29)	4.87 (1.86)	.053
Awareness (sum of consequences and knowledge)	9.8 (3.2)	10.5 (2.0)	9.7 (3.4)	.071

[1]Mean (SD); n (%)

[2] Welch Two Sample t-test; Pearson's Chi-squared test; Fisher's exact test

- **Statistically Significant Changes in ALL Study Outcomes!**
  - Perceived *Social Support* & Strength *of Family Relationships*
  - *Cultural Identity*
  - *Religion/Spirituality*
  - *Knowledge*: Depression; Anxiety; Domestic Violence
  - Familiarity w/ *Local Services*
  - Confidence in using ***coping skills/tools*** – GREATEST IMPROVEMENT

Focus Groups—Key Findings

- **Theme 1: Strengthening the family structure**
  - Improved communication and healthy expressions of love and warmness through words and affection.
- **Theme 2: Reducing social, cultural, and linguistic isolation**
  - A safe and welcoming space to learn, share, and connect with other DV survivors and not feel judged or ashamed.
- **Theme 3: Attaining self-love and emotional healing**
  - Learned to recognize their self-worth, acceptance, and connection with themselves for their own personal and family wellbeing
- **Theme 4:Strengthening one's capacity to practice coping skills**
  - Learned abilities and techniques to cope with stressful situations, such as deep breathing, mindfulness, positive affirmations, establishing goals, etc. Participants found happiness and meaning with simple activities such as going out for a walk, watering the plants, listening to the birds, and observing nature.

Testimony—Community Advisory Board member

Leonor Hernandez

Community Advisory Board Member

Former LwL Graduate

To summarize, it is important to

- Support culturally and linguistically appropriate initiatives and programs that reflect the needs of the community they serve.
- Value and recognize the work of community Promotoras/es.
- Support, value, and respect indigenous healing practices.
- Advocate and support the access to linguistically appropriate mental health treatments

THANK YOU

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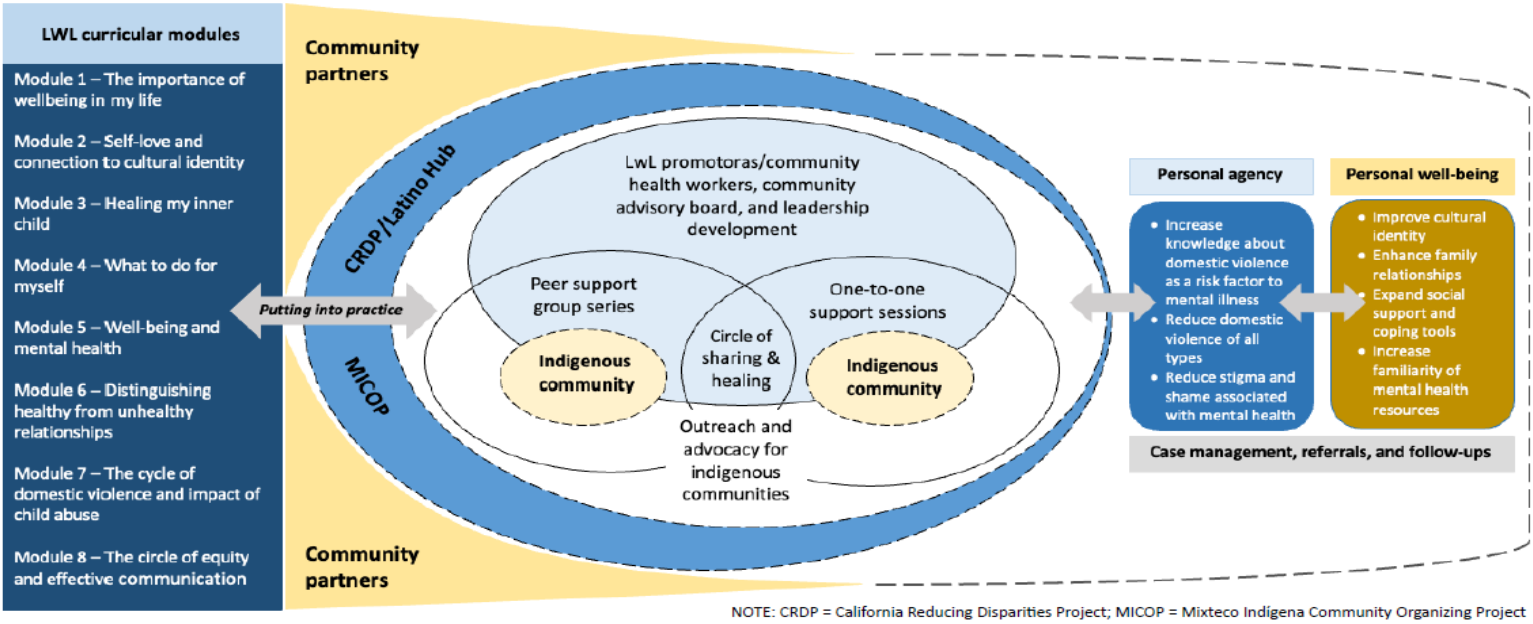
Living with Love (LwL) or Viviendo con Amor is MICOP's direct prevention and early intervention mental health and domestic violence program developed to address depression, anxiety, and other mental health issues linked to the impact of domestic violence that Mexican Migrant Indigenous women experience. Practicing sense of autonomy or feeling in charge of one's life circumstances that strengthens resilience and personal well-being is the foundation of LwL. A total of 168 women participated in LwL between 2017 and 2021. Of the 168 women, 51% were born in Oaxaca, Mexico, 14% in Michoacan, Mexico, and the rest from other regions of Mexico. In terms of language spoken at home, nearly half of participants reported speaking an indigenous language or variant (i.e., Mixteco, 42%; Zapoteco, 3%), 40% Spanish, 10% English, and 5% other. These numbers indicate that LwL served the intended Mexican Indigenous population. The strength and robustness of effects observed in this evaluation, illustrate the power of LwL for improving mental health and wellbeing among Mexican migrant women of varied ages, marital status, and family size, including those who speak indigenous languages only or in combination with Spanish.

The LwL 8-module curriculum is the mode of practice for participants to recognize the negative impact of domestic violence, confront their perpetrator, and reconnect with their self—self-love, self-respect, self-worth, and self-empowerment—to achieve well-being and full participation in family and community life. In general, combining in-person peer support groups and one-to-one support sessions with real-life experiential learning (putting into practice) under the guidance of a promotora resulted in improved personal agency and well-being among LwL participants. Figure 1. shows a model that conceptualizes the key components of LwL and evaluated to determine a level of effectiveness. This model and evaluation is guided by community-based participatory research approach to increase the efficacy in the implementation of LwL.

The LwL Mental Wellness Model

FIGURE 1. LwL Model for Addressing domestic Violence and Achieve Well-being



NOTE: CRDP = California Reducing Disparities Project; MICOP = Mixteco Indígena Community Organizing Project

The key to the effectiveness of LwL is the trained promotoras facilitating the 8-module group series. The promotoras are trusted members of the indigenous community and former participants of LwL. The LwL promotoras were successful in connecting with LwL participants by sharing their lived/life experiences and spoken language (Spanish and Mixteco) during LwL's circle of sharing and healing. The promotoras remain current with the cultural and language needs of the LwL participants and making necessary modifications to the LwL instruction and activities. With COVID-19, the LwL staff and promotoras changed to one-to-one support sessions (both virtual and later in-person) that led to a different intervention dynamic yet produced effective results.

KEY FINDINGS — QUALITATIVE

Theme 1. Strengthening the family structure — LwL participants highlighted the healthy changes they made in their homes by communicating healthy expressions of love with their children. This finding means that participants were able to recognize the long-lasting effects of trauma from domestic violence. One participant who left an abusive relationship recalls, "I can see my children's reactions differently when I express them verbal affection like saying, 'I love you'".

Theme 2. Reducing social, cultural, and linguistic isolation — Participants described LwL as a safe and welcoming space to learn, share, and connect with other domestic violence survivors and not feel judged or shamed. "[...before LwL] I was ashamed and scared, but then I started to feel confident... These *pláticas* help a lot to value ourselves as women," said one LwL participant. These interactions based on cultural, language, trust, empathy, and shared lived experiences led people to feel more connected and understood.

Theme 3. LwL during COVID-19 — in response to the pandemic's restrictions with in-person interactions, LwL adopted a one-to-one peer support format that allowed for a more private and quality space for participants to express and share in a more personalized manner their struggles with domestic violence. "There was more intimacy, I was able to release what I was carrying without exposing myself to other people," said one participant.

Theme 4. Attaining self-love and emotional healing — The mental and emotional growth that participants gained through LwL was evident in their active participation in the circle of sharing and healing. The participants credit LwL module 3 (healing my inner child) session. One participant expressed "a deep sadness within myself as a child... I need to heal to enjoy what I have now [and love myself]". Participants recognized the importance of healing their traumas that were contributing to their mental health.

Theme 5. Knowledge gaps on mental wellness and the impact of domestic violence — LwL participants' knowledge (health literacy) regarding barriers for accessing mental health and domestic violence support and resources improved. "We don't seek help because of fear to talk [or] that [providers] won't understand us... or due to the lack of [knowing] and insurance," reported on participant. Domestic violence is a risk factor affecting migrant indigenous communities and ultimately their health and mental well-being.

Theme 6. Strengthening one's capacity to practice coping skills — LwL participants gained important tools to better manage daily stressors. Simply being mindful (mindfulness) of one's own behaviors, thoughts, and emotions were central to recognizing the value of "going for a walk... the beauty of [nature]... thank God for everything we have," said one participant. LwL's education and tools functions as a protective factor for addressing life's stressors.

KEY FINDINGS — QUANTITATIVE

95% OF PARTICIPANTS REPORTED THAT THEY WOULD CONTINUE THEIR PARTICIPATION IN A SMALL PEER SUPPORT GROUP SIMILAR TO LWL. ALSO, 84% SAID THEY WOULD SEEK SERVICES FROM A PSYCHOLOGIST. THIS FINDING CAN INFORM PRACTICES AROUND REDUCING STIGMA.

92% OF PARTICIPANTS AT THE POSTTEST SHOWED GROWTH IN THEIR KNOWLEDGE ABOUT DEPRESSION COMPARED TO PARTICIPANTS AT BASELINE (56%). THIS FINDING COULD MEAN THAT PARTICIPANTS ARE MORE LIKELY TO ACCESS AND USE SERVICES DUE TO THE INCREASE IN HEALTH LITERACY.

54% OF PARTICIPANTS AT THE POSTTEST SHOWED GROWTH IN THEIR KNOWLEDGE ABOUT ANXIETY COMPARED TO PARTICIPANTS AT BASELINE (36%). THE GROWTH IS SIGNIFICANT AND COULD MEAN THAT PARTICIPANTS FEEL LESS ANXIOUS OR LESS NERVOUS SEEKING SERVICES WHEN THEY NEED THEM.

54% OF PARTICIPANTS AT THE POSTTEST REPORTED AN INCREASE IN BEING MORE AWARE OF A DOMESTIC VIOLENCE SAFETY PLAN COMPARED TO 10% AT BASELINE. THIS FINDING IS IMPORTANT IN SHOWING THAT PARTICIPANTS RECOGNIZE DOMESTIC VIOLENCE AS A RISK FACTOR TO THEIR WELL-BEING.

In conclusion, the stories and date captured throughout the program implementation and evaluation speak to the community's satisfaction with LwL, elevating the cultural appropriateness of the program for its empathy, sense of community and respect and resilience building. Moreover, the strength, robustness and duration of effects observed illustrate the power of LwL for improving health and mental health well-being among Mexican immigrant women. Furthermore, these data provide considerable evidence that adapting the program delivery approach to meet the changing needs of the community does not negatively impact effectiveness. As has been noted, community-based practices are more likely to be successful in reducing mental health disparities for our migrant indigenous communities if the solutions and strategies appropriately reflect the cultural and linguistic uniqueness of this historically underserved population.

For more information, please contact us at 805-302-1503 or 805-744-0440
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ROSENBERG'S RULES OF ORDER: PARLIAMENTARY PROCEDURE FOR PUBLIC MEETINGS

Ventura County Behavioral Health Advisory Board Meeting
October 17, 2022

Jason Canger
Ventura County Counsel's Office

Introduction

- Parliamentary Procedure
  - A basic set of rules for the orderly conduct or process of a meeting
  - Allows everyone to comment and be heard
  - Allows decisions to be made clearly and without confusion to the action taken
- What We're Talking About? Rules for:
  - Order of business
  - Consideration of Items
  - Motions and Voting
  - Debate and Public Comment
  - Courtesy and decorum
  - Role of the Chair

BHAB Bylaws

- The bylaws specifically adopt Rosenberg's Rules: "Except where state law or regulations, County ordinances, County Counsel opinions or these bylaws apply, the current edition of Rosenberg's Rules of Order shall govern the procedures of the BHAB." (BHAB Bylaws, Art. IX.)

- "Applicable state law" includes the Brown Act, which would trump any conflicting parliamentary rule

Parliamentary & Rosenberg's Rules: Introduction

- Parliamentary Rules - In General
  - Parliamentary rules, like Rosenberg's Rules, are not law or regulation
  - They are widely accepted procedural rules and guidelines intending to create a meeting environment where members of boards/legislative bodies and the public can attend to business efficiently, fairly, and with full participation
  - They establish an orderly meeting process and encourage courtesy and civility
- Rosenberg's Rules
  - One set or example of parliamentary rules of procedure; there are several
  - Rosenberg's are an abridged version of "Robert's Rules of Order," which were developed originally for use by larger legislative bodies (i.e., British Parliament)
  - Rosenberg's Rules are often followed and used by smaller legislative bodies (counties and cities)
- NOTE: Parliamentary rules are default rules/guidelines; specific rules from statute or BHAB Bylaws must be followed

Rosenberg's Rules of Order: Foundation

- Rules Should Establish Order
  - The primary purpose of parliamentary rules is to establish a framework for the orderly conduct of meetings
- Rules Should Be Clear and User-Friendly
  - Rules should be clear to foster understanding and participation by everyone
  - Rules should be simple so that the public feels welcome to participate in the process
- Rules Should Enforce the Majority and Protect the Minority
  - Rules must allow the majority to express itself and fashion a result, while permitting the minority to participate and express itself but not dominate
  - Consistent with basic principles of democracy

Rosenberg's Rules of Order: Basic Principles

- Board must act as a body
- Board should conduct its business orderly and efficiently
- Board must act as a majority
- Every member should have equal opportunity to participate
- Rules should be followed consistently and uniformly
- Decisions should be based on merits, not manipulation, of the rules
- Rules should help, not hinder, meeting conduct and process

Rosenberg's Rules of Order: Specific Rules and Applications

- Order of Business
- Consideration of Items
- Motions and Voting
- Debate and Public Comment
- Courtesy and Decorum
- Role of the Chair

Rosenberg's Rules of Order: Order of Business

- Need to Establish a Quorum
  - A quorum is the minimum number of members of the body who must be present at a meeting for business to be legally transacted
  - A quorum can be lost if a member departs the meeting or leaves the dais
- Determining a Quorum
  - The default rule is that a quorum is one member more than half of the body's membership
  - WIC 5604.5 (c) requires BHAB to develop bylaws that "[e]stablish that a quorum be one person more than one-half of the appointed members."
  - BHAB Bylaws, Art. IV(A)(6): "A quorum shall be defined as one person more than half of the appointed members. The definition of appointed members excludes all vacant positions. A quorum shall be required for any action of the BHAB."

Rosenberg's Rules of Order: Order of Business

- Agendas
  - Meetings are governed by agendas, which should serve as a roadmap for the meeting and consideration of items
- Overlap with Brown Act
  - Brown Act requires written agendas to be publicly posted to notify interested persons of items and business the legislative bodies of local governments/public agencies may transact
  - Brown Act generally prohibits action on items and business not agendized
  - Brown Act requirements should always be followed over parliamentary rules
  - BHAB Bylaws: "The Brown Act: All meetings of the BHAB shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies." (BHAB Bylaws, Art. IV(A)(2).)

Rosenberg's Rules of Order: Order of Business

- BHAB Bylaws include some process for meetings:

C. Meeting and Agenda Format

1) BHAB regular meetings shall be conducted by the Chairperson.

a) The Chairperson shall ask for introductions of the members and confirm the existence of a quorum.

b) Approval of minutes of the previous meeting may be included.

c) Reports from officers and committees may be included.

d) Items identified as action items on the agenda by the Chairperson will be addressed and a vote will be taken.

(BHAB Bylaws, Art. IV(C).)

- Where "gaps" in process exist, Rosenberg's Rules may be used to fill in

Rosenberg's Rules of Order: Consideration of Items - Steps

1. Chair announces the item number and the item topic/subject
   - May also announce the recommended action if any
2. Chair invites appropriate person (member, staff) to present the item
3. Chair asks the board members whether there are questions regarding the presentation or item for the presenter
4. Chair invites public comment
   - Comment time may be limited if there several speakers wishing to comment the item
5. Chair invites a motion and determines whether another member wishes to second the motion
   - Once a motion and a second, it's good practice for the chair to announce the name of the members who moved the item/action and seconded it

Rosenberg's Rules of Order: Consideration of Items - Steps

6. If a motion and a second, chair should make sure everyone understands the motion
   - Chair repeats (or summarizes) motion before vote (preferred)
   - Chair asks maker of motion to repeat it
   - Chair asks clerk or secretary to repeat motion
7. Chair invites board member discussion on the motion
   - If there is little or no board discussion, then vote on motion should proceed immediately; not necessary to restate motion
   - But if there is substantial discussion or debate of the motion, then Chair should repeat the motion before the vote
8. Chair takes the vote and then announces the result of the vote
   - i.e., "motion passes" or "motion fails"

Rosenberg's Rules of Order: Motions and Voting

- Motions in General
- Three Basic Motions
- Multiple Motions Before the Body
- Majority and Super-Majority votes
- Counting Votes
- Motion to Reconsider

Rosenberg's Rules of Order: Motions

- Motions in General
  - Motions are the vehicles by which a body takes action; they are decision-making vehicles
  - It's good practice to have a motion before the body prior to discussion; helps focus the members, discussion, and comment; but not necessarily required and staff recommendation may accomplish the same
- Making a Motion - Process
  - Chair initiates the process at the appropriate time (after presentation of the item)
    - Chair may invite a motion, suggest a motion, or make the motion himself/herself
  - Chair recognizes a member
  - The member makes the desired motion (i.e., "I move that…)

Rosenberg's Rules of Order: Motions

- The Three Basic Motions
  - The Basic Motion
    - The original motion that puts forward an action or decision on the item for the body's consideration and discussion
    - i.e., "I move…"
  - The Amended Motion
    - The motion that amends or modifies in some way the motion originally put forward and currently being considered/discussed; includes "friendly amendments" proposed by other members to clarify the original motion
    - i.e., "I move that we amend the motion to…by…"
  - The Substitute or Alternative Motion
    - A motion to completely do away with the original motion before the body
    - This motion throws out the original motion and substitutes a different motion in its place

Rosenberg's Rules of Order: Motions

- The Motion to Reconsider – a special motion
  - A tenet of good governance and parliamentary procedure is finality
    - The must be some end or closure to an item; so items are deemed closed after vote taken
    - UNLESS a Motion to Reconsider is timely and properly made
  - Requirements for a Motion to Reconsider:
    - Only a simple majority is required to pass the Motion BUT…
    - The Motion must be made at the meeting where the item was first voted on; AND
    - The Motion can be made only by a member that voted in the majority on the original motion (although a minority member may second the Motion)
  - NOTE: These requirements make sense or else a minority member could move to reconsider, and bring the item back, again and again
  - If the Motion passes, then the original item is back before the body, and the body may discuss/debate and consider new motions on the item as if it were before the body for the first time.

Rosenberg's Rules of Order: Motions

- Multiple Motions Before the Body – Process
  - Chair can limit the number of motions made by members if necessary to conduct orderly business
    - Several pending motions at the same time is difficult for everyone to manage
    - No more than three at a time is a good rule of thumb
  - In general, the Chair should conduct votes on pending motions in the "reverse order" they were made
  - BASIC EXAMPLE
    - Original motion made; then an amended motion; and then a substitute motion
    - By voting on the substitute motion first, the original and amended motions may be mooted; if the substitute motion fails, then the amended motion may pass and moot the need for a vote on the original motion

Rosenberg's Rules of Order: Voting

- Counting and Determining Votes
  - Starts simple but can get complicated
- Most motions pass with a simple majority vote
  - Most BHAB actions/items will require a simple majority vote
  - Simple majority vote = one vote more than 50% of the body
- Other motions require a two-thirds majority vote
  - Some BHAB actions/items require a two-thirds majority vote, i.e., amendment to bylaws (BHAB Bylaws, Art. X.)
  - Two-thirds majority – double the number of "NOs" voted to determine the number of votes necessary for an item to pass with a two-thirds majority
  - i.e., for a 7-member body, if two members vote "NO," then a "YES" vote of at least four members is required for the item to pass with a two-thirds majority

Rosenberg's Rules of Order: Voting

- Tie Votes
  - In the event of a tie vote, the motion always fails before an affirmative vote is required to pass any motion
- Abstentions
  - Two options under Rosenberg's Rules
    1. Default Rule: Count only the votes of members "present and voting"; abstentions would not be counted as "YES" or "NO" votes; OR
    2. Count votes of members "present"; abstentions would be counted as "NO" votes
  - But must check against applicable statutes and bylaws
    - Both the Welfare and Institutions Code and BHAB Bylaws are silent on how to count abstentions; therefore, the above Default Rule applies (county the votes of only those "present and voting"
  - NOTE: Abstaining members **are** counted for purpose of determining a quorum for that particular item

Rosenberg's Rules of Order: Debate and Public Comment

- Debate
  - All motions are subject to "free and open" discussion and debate (including public comment)
  - Debate can continue as long as members wish to discuss an item, but the Chair has the authority to decide that it is time to move on, call for motions, and vote on an item
  - Debate should be courteous and respect of other members and the public

Rosenberg's Rules of Order: Debate and Public Comment

- Public Comment
  - BHAB meetings are subject to the Brown Act, and thus must (i) provide the public opportunity to comment on all items on the agenda and (ii) provide public a general opportunity to comment on items not on the agenda
  - Generally Rosenberg's Rules facilitate public-friendly meetings
  - Nonetheless, in order to encourage public participation, the Chair should:
    1. Explain to the public what the body **will** be doing (on an item by item basis)
    2. Keep the public informed while the body **is** doing it
    3. When the body has acted, tell the public what the body **did** (a brief statement summarizing the action taken)

Rosenberg's Rules of Order: Courtesy and Decorum

- All members – not just the Chair – should strive to maintain common courtesy and decorum
- Good governance and decisions result from full, complete participation
  - But to ensure orderly meetings, it is best for one person at a time to have the floor and for members to be recognized by the Chair before speaking
  - Members should avoid interrupting other speakers and public comment; if necessary, members should seek recognition from the Chair rather than interrupting the speaker
- Debate and discussion should be focused on the proposed item or recommended action
  - Topics outside the scope of the item or motion, and of personalities, should be avoided

Rosenberg's Rules of Order: Role of the Chair

- Chair runs the conduct of meetings
  - Chair applies the BHAB Bylaws and Rosenberg's Rules where applicable to ensure orderly conduct of meetings; thus Chair should be comfortable with the Bylaws and the Rules
  - Decisions of the Chair are final unless conflict with Bylaws or Rosenberg's Rules, or overruled by a majority of the BHAB members
- Chair should focus debate/discussion and ensure courtesy/decorum are observed
  - Chair has the right to cut off discussion that is too personal, too loud, or too crude
- Chair may limit time allotted to speakers, including members of the body

Rosenberg's Rules of Order: Role of the Chair

- Because the Chair presides over and runs conduct of meetings, the Chair usually plays a less active rule during debate and discussion
  - Chair should strive to be the last to speak during debate and discussion
  - Chair should not make a motion or second a motion UNLESS he/she is convinced that no other member will do so
- Notwithstanding this guidance, the Chair always has the right to participate in debate, discussion, and the decision-making of the body

QUESTIONS

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Rosenberg's Rules of Order

REVISED 2011

Simple Rules of Parliamentary Procedure for the 21st Century

By Judge Dave Rosenberg

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About the Author

Dave Rosenberg is a Superior Court Judge in Yolo County. He has served as presiding judge of his court, and as presiding judge of the Superior Court Appellate Division. He also has served as chair of the Trial Court Presiding Judges Advisory Committee (the committee composed of all 58 California presiding judges) and as an advisory member of the California Judicial Council. Prior to his appointment to the bench, Rosenberg was member of the Yolo County Board of Supervisors, where he served two terms as chair. Rosenberg also served on the Davis City Council, including two terms as mayor. He has served on the senior staff of two governors, and worked for 19 years in private law practice. Rosenberg has served as a member and chair of numerous state, regional and local boards. Rosenberg chaired the California State Lottery Commission, the California Victim Compensation and Government Claims Board, the Yolo-Solano Air Quality Management District, the Yolo County Economic Development Commission, and the Yolo County Criminal Justice Cabinet. For many years, he has taught classes on parliamentary procedure and has served as parliamentarian for large and small bodies.

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Introduction

The rules of procedure at meetings should be simple enough for most people to understand. Unfortunately, that has not always been the case. Virtually all clubs, associations, boards, councils and bodies follow a set of rules — *Robert's Rules of Order* — which are embodied in a small, but complex, book. Virtually no one I know has actually read this book cover to cover. Worse yet, the book was written for another time and for another purpose. If one is chairing or running a parliament, then *Robert's Rules of Order* is a dandy and quite useful handbook for procedure in that complex setting. On the other hand, if one is running a meeting of say, a five-member body with a few members of the public in attendance, a simplified version of the rules of parliamentary procedure is in order.

Hence, the birth of *Rosenberg's Rules of Order*.

What follows is my version of the rules of parliamentary procedure, based on my decades of experience chairing meetings in state and local government. These rules have been simplified for the smaller bodies we chair or in which we participate, slimmed down for the 21st Century, yet retaining the basic tenets of order to which we have grown accustomed. Interestingly enough, *Rosenberg's Rules* has found a welcoming audience. Hundreds of cities, counties, special districts, committees, boards, commissions, neighborhood associations and private corporations and companies have adopted *Rosenberg's Rules* in lieu of *Robert's Rules* because they have found them practical, logical, simple, easy to learn and user friendly.

This treatise on modern parliamentary procedure is built on a foundation supported by the following four pillars:

1. **Rules should establish order.** The first purpose of rules of parliamentary procedure is to establish a framework for the orderly conduct of meetings.
2. **Rules should be clear.** Simple rules lead to wider understanding and participation. Complex rules create two classes: those who understand and participate; and those who do not fully understand and do not fully participate.
3. **Rules should be user friendly.** That is, the rules must be simple enough that the public is invited into the body and feels that it has participated in the process.
4. **Rules should enforce the will of the majority while protecting the rights of the minority.** The ultimate purpose of rules of procedure is to encourage discussion and to facilitate decision making by the body. In a democracy, majority rules. The rules must enable the majority to express itself and fashion a result, while permitting the minority to also express itself, but not dominate, while fully participating in the process.

Establishing a Quorum

The starting point for a meeting is the establishment of a quorum. A quorum is defined as the minimum number of members of the body who must be present at a meeting for business to be legally transacted. The default rule is that a quorum is one more than half the body. For example, in a five-member body a quorum is three. When the body has three members present, it can legally transact business. If the body has less than a quorum of members present, it cannot legally transact business. And even if the body has a quorum to begin the meeting, the body can lose the quorum during the meeting when a member departs (or even when a member leaves the dais). When that occurs the body loses its ability to transact business until and unless a quorum is reestablished.

The default rule, identified above, however, gives way to a specific rule of the body that establishes a quorum. For example, the rules of a particular five-member body may indicate that a quorum is four members for that particular body. The body must follow the rules it has established for its quorum. In the absence of such a specific rule, the quorum is one more than half the members of the body.

The Role of the Chair

While all members of the body should know and understand the rules of parliamentary procedure, it is the chair of the body who is charged with applying the rules of conduct of the meeting. The chair should be well versed in those rules. For all intents and purposes, the chair makes the final ruling on the rules every time the chair states an action. In fact, all decisions by the chair are final unless overruled by the body itself.

Since the chair runs the conduct of the meeting, it is usual courtesy for the chair to play a less active role in the debate and discussion than other members of the body. This does not mean that the chair should not participate in the debate or discussion. To the contrary, as a member of the body, the chair has the full right to participate in the debate, discussion and decision-making of the body. What the chair should do, however, is strive to be the last to speak at the discussion and debate stage. The chair should not make or second a motion unless the chair is convinced that no other member of the body will do so at that point in time.

The Basic Format for an Agenda Item Discussion

Formal meetings normally have a written, often published agenda. Informal meetings may have only an oral or understood agenda. In either case, the meeting is governed by the agenda and the agenda constitutes the body's agreed-upon roadmap for the meeting. Each agenda item can be handled by the chair in the following basic format:

First, the chair should clearly announce the agenda item number and should clearly state what the agenda item subject is. The chair should then announce the format (which follows) that will be followed in considering the agenda item.

Second, following that agenda format, the chair should invite the appropriate person or persons to report on the item, including any recommendation that they might have. The appropriate person or persons may be the chair, a member of the body, a staff person, or a committee chair charged with providing input on the agenda item.

Third, the chair should ask members of the body if they have any technical questions of clarification. At this point, members of the body may ask clarifying questions to the person or persons who reported on the item, and that person or persons should be given time to respond.

Fourth, the chair should invite public comments, or if appropriate at a formal meeting, should open the public meeting for public input. If numerous members of the public indicate a desire to speak to the subject, the chair may limit the time of public speakers. At the conclusion of the public comments, the chair should announce that public input has concluded (or the public hearing, as the case may be, is closed).

Fifth, the chair should invite a motion. The chair should announce the name of the member of the body who makes the motion.

Sixth, the chair should determine if any member of the body wishes to second the motion. The chair should announce the name of the member of the body who seconds the motion. It is normally good practice for a motion to require a second before proceeding to ensure that it is not just one member of the body who is interested in a particular approach. However, a second is not an absolute requirement, and the chair can proceed with consideration and vote on a motion even when there is no second. This is a matter left to the discretion of the chair.

Seventh, if the motion is made and seconded, the chair should make sure everyone understands the motion.

This is done in one of three ways:

1. The chair can ask the maker of the motion to repeat it;
2. The chair can repeat the motion; or
3. The chair can ask the secretary or the clerk of the body to repeat the motion.

Eighth, the chair should now invite discussion of the motion by the body. If there is no desired discussion, or after the discussion has ended, the chair should announce that the body will vote on the motion. If there has been no discussion or very brief discussion, then the vote on the motion should proceed immediately and there is no need to repeat the motion. If there has been substantial discussion, then it is normally best to make sure everyone understands the motion by repeating it.

Ninth, the chair takes a vote. Simply asking for the "ayes" and then asking for the "nays" normally does this. If members of the body do not vote, then they "abstain." Unless the rules of the body provide otherwise (or unless a super majority is required as delineated later in these rules), then a simple majority (as defined in law or the rules of the body as delineated later in these rules) determines whether the motion passes or is defeated.

Tenth, the chair should announce the result of the vote and what action (if any) the body has taken. In announcing the result, the chair should indicate the names of the members of the body, if any, who voted in the minority on the motion. This announcement might take the following form: "The motion passes by a vote of 3-2, with Smith and Jones dissenting. We have passed the motion requiring a 10-day notice for all future meetings of this body."

Motions in General

Motions are the vehicles for decision making by a body. It is usually best to have a motion before the body prior to commencing discussion of an agenda item. This helps the body focus.

Motions are made in a simple two-step process. First, the chair should recognize the member of the body. Second, the member of the body makes a motion by preceding the member's desired approach with the words "I move … "

A typical motion might be: "I move that we give a 10-day notice in the future for all our meetings."

The chair usually initiates the motion in one of three ways:

1. **Inviting the members of the body to make a motion,** for example, "A motion at this time would be in order."
2. **Suggesting a motion to the members of the body,** "A motion would be in order that we give a 10-day notice in the future for all our meetings."
3. **Making the motion.** As noted, the chair has every right as a member of the body to make a motion, but should normally do so only if the chair wishes to make a motion on an item but is convinced that no other member of the body is willing to step forward to do so at a particular time.

The Three Basic Motions

There are three motions that are the most common and recur often at meetings:

The basic motion. The basic motion is the one that puts forward a decision for the body's consideration. A basic motion might be: "I move that we create a five-member committee to plan and put on our annual fundraiser."

The motion to amend. If a member wants to change a basic motion that is before the body, they would move to amend it. A motion to amend might be: "I move that we amend the motion to have a 10-member committee." A motion to amend takes the basic motion that is before the body and seeks to change it in some way.

The substitute motion. If a member wants to completely do away with the basic motion that is before the body, and put a new motion before the body, they would move a substitute motion. A substitute motion might be: "I move a substitute motion that we cancel the annual fundraiser this year."

"Motions to amend" and "substitute motions" are often confused, but they are quite different, and their effect (if passed) is quite different. A motion to amend seeks to retain the basic motion on the floor, but modify it in some way. A substitute motion seeks to throw out the basic motion on the floor, and substitute a new and different motion for it. The decision as to whether a motion is really a "motion to amend" or a "substitute motion" is left to the chair. So if a member makes what that member calls a "motion to amend," but the chair determines that it is really a "substitute motion," then the chair's designation governs.

A "friendly amendment" is a practical parliamentary tool that is simple, informal, saves time and avoids bogging a meeting down with numerous formal motions. It works in the following way: In the discussion on a pending motion, it may appear that a change to the motion is desirable or may win support for the motion from some members. When that happens, a member who has the floor may simply say, "I want to suggest a friendly amendment to the motion." The member suggests the friendly amendment, and if the maker and the person who seconded the motion pending on the floor accepts the friendly amendment, that now becomes the pending motion on the floor. If either the maker or the person who seconded rejects the proposed friendly amendment, then the proposer can formally move to amend.

Multiple Motions Before the Body

There can be up to three motions on the floor at the same time. The chair can reject a fourth motion until the chair has dealt with the three that are on the floor and has resolved them. This rule has practical value. More than three motions on the floor at any given time is confusing and unwieldy for almost everyone, including the chair.

When there are two or three motions on the floor (after motions and seconds) at the same time, the vote should proceed *first* on the *last* motion that is made. For example, assume the first motion is a basic "motion to have a five-member committee to plan and put on our annual fundraiser." During the discussion of this motion, a member might make a second motion to "amend the main motion to have a 10-member committee, not a five-member committee to plan and put on our annual fundraiser." And perhaps, during that discussion, a member makes yet a third motion as a "substitute motion that we not have an annual fundraiser this year." The proper procedure would be as follows:

First, the chair would deal with the *third* (the last) motion on the floor, the substitute motion. After discussion and debate, a vote would be taken first on the third motion. If the substitute motion *passed*, it would be a substitute for the basic motion and would eliminate it. The first motion would be moot, as would the second motion (which sought to amend the first motion), and the action on the agenda item would be completed on the passage by the body of the third motion (the substitute motion). No vote would be taken on the first or second motions.

Second, if the substitute motion *failed*, the chair would then deal with the second (now the last) motion on the floor, the motion to amend. The discussion and debate would focus strictly on the amendment (should the committee be five or 10 members). If the motion to amend *passed*, the chair would then move to consider the main motion (the first motion) as *amended*. If the motion to amend *failed,* the chair would then move to consider the main motion (the first motion) in its original format, not amended.

Third, the chair would now deal with the first motion that was placed on the floor. The original motion would either be in its original format (five-member committee), or if *amended*, would be in its amended format (10-member committee). The question on the floor for discussion and decision would be whether a committee should plan and put on the annual fundraiser.

To Debate or Not to Debate

The basic rule of motions is that they are subject to discussion and debate. Accordingly, basic motions, motions to amend, and substitute motions are all eligible, each in their turn, for full discussion before and by the body. The debate can continue as long as members of the body wish to discuss an item, subject to the decision of the chair that it is time to move on and take action.

There are exceptions to the general rule of free and open debate on motions. The exceptions all apply when there is a desire of the body to move on. The following motions are not debatable (that is, when the following motions are made and seconded, the chair must immediately call for a vote of the body without debate on the motion):

Motion to adjourn. This motion, if passed, requires the body to immediately adjourn to its next regularly scheduled meeting. It requires a simple majority vote.

Motion to recess. This motion, if passed, requires the body to immediately take a recess. Normally, the chair determines the length of the recess which may be a few minutes or an hour. It requires a simple majority vote.

Motion to fix the time to adjourn. This motion, if passed, requires the body to adjourn the meeting at the specific time set in the motion. For example, the motion might be: "I move we adjourn this meeting at midnight." It requires a simple majority vote.

Motion to table. This motion, if passed, requires discussion of the agenda item to be halted and the agenda item to be placed on "hold." The motion can contain a specific time in which the item can come back to the body. "I move we table this item until our regular meeting in October." Or the motion can contain no specific time for the return of the item, in which case a motion to take the item off the table and bring it back to the body will have to be taken at a future meeting. A motion to table an item (or to bring it back to the body) requires a simple majority vote.

Motion to limit debate. The most common form of this motion is to say, "I move the previous question" or "I move the question" or "I call the question" or sometimes someone simply shouts out "question." As a practical matter, when a member calls out one of these phrases, the chair can expedite matters by treating it as a "request" rather than as a formal motion. The chair can simply inquire of the body, "any further discussion?" If no one wishes to have further discussion, then the chair can go right to the pending motion that is on the floor. However, if even one person wishes to discuss the pending motion further, then at that point, the chair should treat the call for the "question" as a formal motion, and proceed to it.

When a member of the body makes such a motion ("I move the previous question"), the member is really saying: "I've had enough debate. Let's get on with the vote." When such a motion is made, the chair should ask for a second, stop debate, and vote on the motion to limit debate. The motion to limit debate requires a two-thirds vote of the body.

NOTE: A motion to limit debate could include a time limit. For example: "I move we limit debate on this agenda item to 15 minutes." Even in this format, the motion to limit debate requires a two-thirds vote of the body. A similar motion is a *motion to object to consideration of an item.* This motion is not debatable, and if passed, precludes the body from even considering an item on the agenda. It also requires a two-thirds vote.

Majority and Super Majority Votes

In a democracy, a simple majority vote determines a question. A tie vote means the motion fails. So in a seven-member body, a vote of 4-3 passes the motion. A vote of 3-3 with one abstention means the motion fails. If one member is absent and the vote is 3-3, the motion still fails.

All motions require a simple majority, but there are a few exceptions. The exceptions come up when the body is taking an action which effectively cuts off the ability of a minority of the body to take an action or discuss an item. These extraordinary motions require a two-thirds majority (a super majority) to pass:

Motion to limit debate. Whether a member says, "I move the previous question," or "I move the question," or "I call the question," or "I move to limit debate," it all amounts to an attempt to cut off the ability of the minority to discuss an item, and it requires a two-thirds vote to pass.

Motion to close nominations. When choosing officers of the body (such as the chair), nominations are in order either from a nominating committee or from the floor of the body. A motion to close nominations effectively cuts off the right of the minority to nominate officers and it requires a two-thirds vote to pass.

Motion to object to the consideration of a question. Normally, such a motion is unnecessary since the objectionable item can be tabled or defeated straight up. However, when members of a body do not even want an item on the agenda to be considered, then such a motion is in order. It is not debatable, and it requires a two-thirds vote to pass.

Motion to suspend the rules. This motion is debatable, but requires a two-thirds vote to pass. If the body has its own rules of order, conduct or procedure, this motion allows the body to suspend the rules for a particular purpose. For example, the body (a private club) might have a rule prohibiting the attendance at meetings by non-club members. A motion to suspend the rules would be in order to allow a non-club member to attend a meeting of the club on a particular date or on a particular agenda item.

Counting Votes

The matter of counting votes starts simple, but can become complicated.

Usually, it's pretty easy to determine whether a particular motion passed or whether it was defeated. If a simple majority vote is needed to pass a motion, then one vote more than 50 percent of the body is required. For example, in a five-member body, if the vote is three in favor and two opposed, the motion passes. If it is two in favor and three opposed, the motion is defeated.

If a two-thirds majority vote is needed to pass a motion, then how many affirmative votes are required? The simple rule of thumb is to count the "no" votes and double that count to determine how many "yes" votes are needed to pass a particular motion. For example, in a seven-member body, if two members vote "no" then the "yes" vote of at least four members is required to achieve a two-thirds majority vote to pass the motion.

What about tie votes? In the event of a tie, the motion always fails since an affirmative vote is required to pass any motion. For example, in a five-member body, if the vote is two in favor and two opposed, with one member absent, the motion is defeated.

Vote counting starts to become complicated when members vote "abstain" or in the case of a written ballot, cast a blank (or unreadable) ballot. Do these votes count, and if so, how does one count them? The starting point is always to check the statutes.

In California, for example, for an action of a board of supervisors to be valid and binding, the action must be approved by a majority of the board. (California Government Code Section 25005.) Typically, this means three of the five members of the board must vote affirmatively in favor of the action. A vote of 2-1 would not be sufficient. A vote of 3-0 with two abstentions would be sufficient. In general law cities in

California, as another example, resolutions or orders for the payment of money and all ordinances require a recorded vote of the total members of the city council. (California Government Code Section 36936.) Cities with charters may prescribe their own vote requirements. Local elected officials are always well-advised to consult with their local agency counsel on how state law may affect the vote count.

After consulting state statutes, step number two is to check the rules of the body. If the rules of the body say that you count votes of "those present" then you treat abstentions one way. However, if the rules of the body say that you count the votes of those "present and voting," then you treat abstentions a different way. And if the rules of the body are silent on the subject, then the general rule of thumb (and default rule) is that you count all votes that are "present and voting."

Accordingly, under the "present and voting" system, you would **NOT** count abstention votes on the motion. Members who abstain are counted for purposes of determining quorum (they are "present"), but you treat the abstention votes on the motion as if they did not exist (they are not "voting"). On the other hand, if the rules of the body specifically say that you count votes of those "present" then you **DO** count abstention votes both in establishing the quorum and on the motion. In this event, the abstention votes act just like "no" votes.

How does this work in practice?
Here are a few examples.

Assume that a five-member city council is voting on a motion that requires a simple majority vote to pass, and assume further that the body has no specific rule on counting votes. Accordingly, the default rule kicks in and we count all votes of members that are "present and voting." If the vote on the motion is 3-2, the motion passes. If the motion is 2-2 with one abstention, the motion fails.

Assume a five-member city council voting on a motion that requires a two-thirds majority vote to pass, and further assume that the body has no specific rule on counting votes. Again, the default rule applies. If the vote is 3-2, the motion fails for lack of a two-thirds majority. If the vote is 4-1, the motion passes with a clear two-thirds majority. A vote of three "yes," one "no" and one "abstain" also results in passage of the motion. Once again, the abstention is counted only for the purpose of determining quorum, but on the actual vote on the motion, it is as if the abstention vote never existed — so an effective 3-1 vote is clearly a two-thirds majority vote.

Now, change the scenario slightly. Assume the same five-member city council voting on a motion that requires a two-thirds majority vote to pass, but now assume that the body **DOES** have a specific rule requiring a two-thirds vote of members "present." Under this specific rule, we must count the members present not only for quorum but also for the motion. In this scenario, any abstention has the same force and effect as if it were a "no" vote. Accordingly, if the votes were three "yes," one "no" and one "abstain," then the motion fails. The abstention in this case is treated like a "no" vote and effective vote of 3-2 is not enough to pass two-thirds majority muster.

Now, exactly how does a member cast an "abstention" vote? Any time a member votes "abstain" or says, "I abstain," that is an abstention. However, if a member votes "present" that is also treated as an abstention (the member is essentially saying, "Count me for purposes of a quorum, but my vote on the issue is abstain.") In fact, any manifestation of intention not to vote either "yes" or "no" on the pending motion may be treated by the chair as an abstention. If written ballots are cast, a blank or unreadable ballot is counted as an abstention as well.

Can a member vote "absent" or "count me as absent?" Interesting question. The ruling on this is up to the chair. The better approach is for the chair to count this as if the member had left his/her chair and is actually "absent." That, of course, affects the quorum. However, the chair may also treat this as a vote to abstain, particularly if the person does not actually leave the dais.

The Motion to Reconsider

There is a special and unique motion that requires a bit of explanation all by itself; the motion to reconsider. A tenet of parliamentary procedure is finality. After vigorous discussion, debate and a vote, there must be some closure to the issue. And so, after a vote is taken, the matter is deemed closed, subject only to reopening if a proper motion to consider is made and passed.

A motion to reconsider requires a majority vote to pass like other garden-variety motions, but there are two special rules that apply only to the motion to reconsider.

First, is the matter of timing. A motion to reconsider must be made at the meeting where the item was first voted upon. A motion to reconsider made at a later time is untimely. (The body, however, can always vote to suspend the rules and, by a two-thirds majority, allow a motion to reconsider to be made at another time.)

Second, a motion to reconsider may be made only by certain members of the body. Accordingly, a motion to reconsider may be made only by a member who voted in the majority on the original motion. If such a member has a change of heart, he or she may make the motion to reconsider (any other member of the body — including a member who voted in the minority on the original motion — may second the motion). If a member who voted in the minority seeks to make the motion to reconsider, it must be ruled out of order. The purpose of this rule is finality. If a member of minority could make a motion to reconsider, then the item could be brought back to the body again and again, which would defeat the purpose of finality.

If the motion to reconsider passes, then the original matter is back before the body, and a new original motion is in order. The matter may be discussed and debated as if it were on the floor for the first time.

Courtesy and Decorum

The rules of order are meant to create an atmosphere where the members of the body and the members of the public can attend to business efficiently, fairly and with full participation. At the same time, it is up to the chair and the members of the body to maintain common courtesy and decorum. Unless the setting is very informal, it is always best for only one person at a time to have the floor, and it is always best for every speaker to be first recognized by the chair before proceeding to speak.

The chair should always ensure that debate and discussion of an agenda item focuses on the item and the policy in question, not the personalities of the members of the body. Debate on policy is healthy, debate on personalities is not. The chair has the right to cut off discussion that is too personal, is too loud, or is too crude.

Debate and discussion should be focused, but free and open. In the interest of time, the chair may, however, limit the time allotted to speakers, including members of the body.

Can a member of the body interrupt the speaker? The general rule is "no." There are, however, exceptions. A speaker may be interrupted for the following reasons:

Privilege. The proper interruption would be, "point of privilege." The chair would then ask the interrupter to "state your point." Appropriate points of privilege relate to anything that would interfere with the normal comfort of the meeting. For example, the room may be too hot or too cold, or a blowing fan might interfere with a person's ability to hear.

Order. The proper interruption would be, "point of order." Again, the chair would ask the interrupter to "state your point." Appropriate points of order relate to anything that would not be considered appropriate conduct of the meeting. For example, if the chair moved on to a vote on a motion that permits debate without allowing that discussion or debate.

Appeal. If the chair makes a ruling that a member of the body disagrees with, that member may appeal the ruling of the chair. If the motion is seconded, and after debate, if it passes by a simple majority vote, then the ruling of the chair is deemed reversed.

Call for orders of the day. This is simply another way of saying, "return to the agenda." If a member believes that the body has drifted from the agreed-upon agenda, such a call may be made. It does not require a vote, and when the chair discovers that the agenda has not been followed, the chair simply reminds the body to return to the agenda item properly before them. If the chair fails to do so, the chair's determination may be appealed.

Withdraw a motion. During debate and discussion of a motion, the maker of the motion on the floor, at any time, may interrupt a speaker to withdraw his or her motion from the floor. The motion is immediately deemed withdrawn, although the chair may ask the person who seconded the motion if he or she wishes to make the motion, and any other member may make the motion if properly recognized.

Special Notes About Public Input

The rules outlined above will help make meetings very public-friendly. But in addition, and particularly for the chair, it is wise to remember three special rules that apply to each agenda item:

Rule One: Tell the public what the body will be doing.

Rule Two: Keep the public informed while the body is doing it.

Rule Three: When the body has acted, tell the public what the body did.

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UPDATED COUNTY ADMINISTRATIVE MANUAL HIGHLIGHTS

Ventura County Behavioral Health Advisory Board Meeting
October 17, 2022

Jason Canger
Ventura County Counsel's Office

Administrative Policy Manual: Background

- Compilation of policies, procedures, and appropriate forms that all County administrative units observe in common to promote internal operational and administrative efficiency and to implement the mission, values, and guiding principles of the County
- The purpose of the Manual is to provide guidelines and direction for County employees and to assist in the management of County business.

Administrative Policy Manual: Purpose

- Mission – to provide superior public service and support so that all residents have the opportunity to improve their quality of life while enjoying the benefits of a safe, healthy, and vibrant community
- Values – build and foster public trust through ethical behavior, transparency and accountability, equitable treatment and respect of all constituents, and excellence in service delivery
- Guiding Principles – serving resident and business communities by:
  - Adopting carefully considered policies
  - Staying competitive through the implementation of proven practices and the effective use of technology
  - Delivering services in a business and constituent friendly, customer-service driven, cost effective manner
  - Utilizing strategic thinking and action
  - Promoting an action-oriented, empowered, and accountable workforce
  - Planning for and developing programs to meet future needs
  - Operating in a fiscally responsible manner

Administrative Policy Manual: Recent Amendments

- Approved by Board of Supervisors at July 12, 2022 meeting
- Amendments to Four General Areas of Manual
  - Operating procedures for Board of Supervisor meetings and agenda
  - Information Technology policies, standards, and guidelines
  - Code of conduct for members of boards and commissions
  - County volunteers

Amendment: Change to Certain County and BOS Procedures

- Three changes to bring Chapter II-11 of Manual in line with current practices:
  - Update BOS agenda format so that CEO comments are heard before supervisor comments
  - Update rules regarding Clerk of the Board's handling, receipt, and distribution of correspondence to supervisors
  - Revise rules and provisions related to use of standardized forms for County travel and business expenses
- No impact on BHAB

Amendment: Change to Information Technology Policies, Standards and Guidelines

- General restructuring of Information Technology Administrative Manual
  - Combination of four separate policies into a single streamlined policy
  - Goal – to garner regularity in IT updates and create a more agile structure so that County IT policies can routinely be reviewed and updated to align with rapid changes occurring in the technology environment
- No impact on BHAB

Amendment: County Volunteers Policy

- Addition of new Chapter VII-25 to Manual
- Authorizes CEO to execute “no cost” volunteer or internship agreements with volunteer organizations, colleges, and universities
- No impact on BHAB

Amendment: Code of Conduct for Members of Boards and Commissions

- Addition of new Chapter II-21 to Manual
- Policy: "The Board is committed to the highest standards of conduct by and among its elected and appointed county officials in the performance of their duties on County Boards and Commissions and the Board seeks to ensure that promoting the common good is the hallmark of the decision-making process."
- General Purpose: "[E]nsure public meetings are conducive to civil discourse, including with respect to controversial matters and disparate viewpoints which is the cornerstone of representative democracy and essential to effective decision-making."

Amendment: Code of Conduct for Members of Boards and Commissions (CONT)

- Applicability: "This Code of Conduct…shall apply to all Board and Commission members appointed by the County of Ventura Board of Supervisors."
- Code of Conduct divided into two parts: (1) anti-discrimination rule and (2) required principles
- Anti-Discrimination Rule: "There shall be no discrimination of any individual because of race, color, national origin, religion (creed), gender, gender expression, age, sexual orientation, marital status, native language, functional limitation, or any other characteristic protected by law."

Amendment: Code of Conduct for Members of Boards and Commissions (CONT)

- Required Principles
  - Promote decisions that serve the public interest and the greatest public good.
  - Actively promote public confidence in county government through board and commission actions.
  - Recognize and support the public's right to know the public's business.
  - Involve citizens in the decision-making process and welcome divergent points of view.
  - Respond to the public in ways that are complete, clear, and easy to understand.
  - Maintain a respectful attitude toward the public, employees, other public officials, and colleagues.
  - Respect and protect privileged confidential information (i.e., personnel matters, litigation).
  - Be a good listener, carefully considering all opinions and points of view.
  - Be informed on the background of matters and issues before the commission or board.

Amendment: Code of Conduct for Members of Boards and Commissions (CONT)

- Required Principles (CONT)
  - Work in partnership with other governmental agencies, political subdivisions, and organizations to further the interest of the County. However, no board or commission member shall hold themselves out as representing the County to any state, county, city, special district or school district, agency or commission, nor to any other organization or members of the public, on any matter unless specifically authorized to do so by the Board of Supervisors.
  - Refer to your appointed position or title will only when attending official meetings or functions and in no case shall the appointed title be used to promote or advance personal or political interests.
  - Avoid outside interests that will interfere or conflict with maintaining an objective and impartial perspective.
  - Carefully guard against conflict of interest or its appearance in actions or decisions.

Amendment: Code of Conduct for Members of Boards and Commissions (CONT)

- Required Principles (CONT)
  - Accepting gifts, services, or any object of value from any source offered to influence a decision is prohibited.
  - Efforts to influence or attempt to influence other officials to act in a manner benefiting personal/financial interests are prohibited.
  - Evaluate recommendations (or decisions) to identify the best service, product, or alternative at minimal cost without sacrificing quality or fiscal responsibility.
  - Comply with all laws, ordinances, policies and regulations applicable to an appointed official and those governing the conduct of meetings.

QUESTIONS

Jason Canger
Ventura County Counsel's Office
jason.canger@ventura.org

COUNTY OF VENTURA	2018 ADMINISTRATIVE POLICY MANUAL	GENERAL INFORMATION CHAPTER II-21
Originating Agency: BOS	Last Issued/Revised July 12, 2022	CODE OF CONDUCT FOR MEMBERS OF BOARDS AND COMMISSIONS
Policy Change Requires:	[x] Board of Supervisors Approval [ ] CEO Approval	

POLICY

It is the policy of the Board of Supervisors to hold public meetings in accordance with the requirements of the Brown Act (Government Code section 54950 et seq.) and any other applicable governing legislation. The Board is committed to the highest standards of conduct by and among its elected and appointed county officials in the performance of their duties on County Boards and Commissions and the Board seeks to ensure that promoting the common good is the hallmark of the decision-making process. A code of conduct for County appointed board and commission members will help ensure public meetings are conducive to civil discourse, including with respect to controversial matters and disparate viewpoints which is the cornerstone of representative democracy and essential to effective decision-making.

GENERAL PROVISIONS

I. Applicability of Code of Conduct

This Code of Conduct is adopted pursuant to Government Code section 25003 and shall apply to all Board and Commission members appointed by the County of Ventura Board of Supervisors (Hereinafter referred to as Appointee(s)).

Except as otherwise provided by law, the failure to strictly observe application of the Code of Conduct shall not affect the jurisdiction of the Board or Commission or invalidate any action taken at a meeting that is otherwise held in conformity with law.

II. Code of Conduct

a. Discrimination: There shall be no discrimination of any individual because of race, color, national origin, religion (creed), gender, gender expression, age, sexual orientation, marital status, native language, functional limitation, or any other characteristic protected by law.

III. Each appointee shall adhere to the following principles:

1. Promote decisions that serve the public interest and promote the greatest public good.
2. Actively promote public confidence in county government through their actions.
3. Recognize and support the public's right to know the public's business.
4. Involve citizens in the decision-making process and welcome divergent points of view.
5. Respond to the public in ways that are complete, clear, and easy to understand.
6. Maintain a respectful attitude toward the public, employees, other public officials, and colleagues.
7. Respect and protect privileged confidential information (i.e., personnel matters, litigation).
8. Be a good listener, carefully considering all opinions and points of view.
9. Be informed on the background on issues before your commission or board.
10. Work in partnership with other governmental agencies, political subdivisions, and organizations to further the interest of the county. However, no board or commission member shall hold themselves out as representing the County to any state, county, city, special district or school district, agency or commission, nor to any other organization or members of the public, on any matter unless specifically authorized to do so by the Board of Supervisors.
11. Reference to an appointed position or title will only be used when attending official meetings or functions and in no case shall the appointed title be used to promote or advance personal or political interests.
12. Avoid outside interests that will interfere or conflict with maintaining an objective and impartial perspective.
13. Carefully guard against conflict of interest or its appearance in actions or decisions.
14. Accepting gifts, services, or any object of value from any source offered to influence a decision is prohibited.
15. Efforts to influence or attempt to influence other officials to act in a manner benefiting personal/financial interests are prohibited.
16. Evaluate recommendations (or decisions) to identify the best service, product, or alternative at minimal cost without sacrificing quality or fiscal responsibility.
17. Comply with all laws, ordinances, policies and regulations applicable to an appointed official and those governing the conduct of meetings.

Director's Update

BHAB General Meeting 10.17.22

October has the following days of significance to highlight:

Hispanic Heritage Month- cont. thru 10/15
Emotional Wellness Month
National Bullying Prevention Month
National Depression and Mental Health Screening Month
LGBT History Month
October 6, National Depression Screening Day
October 3-9, Mental Health (Illness) Awareness Week
October 10, World Mental Health Day
October 23-31, Red Ribbon Week (Drug-Free Youth)

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

Access and Outreach Division:

- We are excited to be onboarding new staff to fill the many vacancies – throughout our division.
- Logrando Bienestar has been part of many back to school nights throughout the county. We continue to collaborate within the various community/agencies to provide outreach and engagement to individuals/families.

Adult Services Division:

- Round 5 (Crisis Continuum) of the Behavioral Health Continuum Infrastructure Program (BHCIP) has been updated. There is $480M being made available (statewide), but no deadline for submission has been announced. VCBH is working with its partners, Oasis Healthcare LLC, and Many Mansions, and exploring the prospect of applying to help fund the 120-bed, locked mental health rehabilitation center proposed for development in Camarillo.
- The Suicide Prevention Forum, *Community Connections*, was held on September 21. The sold-out, in-person gathering was attended by more than 320 community members and the follow-up virtual event September 29th had more than 260 registrants. Videos can be found on our YouTube channel linked on the wellnesseveryday.org website.

- As a part of the MHSA Community Planning Process (in support of the upcoming three-year plan), results from the Community Health Needs Assessment will be reviewed on November 29 in Oxnard and November 30 in Santa Paula. Both in-person events will be from 6:00 – 7:30 PM. Daytime virtual events are being planned with more details to follow.

Youth and Family (Y&F) Services Division:

Division Highlights

- The Youth & Family Division held our Fall Town Hall on Oct. 6 at Mission Oaks Park in Camarillo. We spent the time having lunch together and participating in team-building activities. It was a great time to reconnect, relax and reunite with peers we've only seen via Zoom. Director Scott Gilman attended and shared a message of support and gratitude for the Y&F staff**.**

Initiatives and Progress

- The VCBH Juvenile Facility Team is in process of adding three therapy groups to the services provided to the youth. They are in process of hiring staff to fill three vacancies by the end of October. They are also supporting the JF to establish a protocol with the facility for distributing overdose kits to the youth for use by them as well as for their loved ones.

Collaborations

- Child Welfare Subsystem administrators in collaboration with Child and Family Services social workers and agency attorneys are participating on a Juvenile Dependency Panel as part of training for Court Appointed Special Advocates (CASA) workers. This panel is held throughout the year and provides an opportunity for CASA workers to learn the different aspects of dependency and agencies providing services.
- In conjunction with VCOE SELPA, the Educationally Related Services teams have been joining district personnel in each region for the revised Annual ERSES training, focusing on efficiency and effectiveness, utilization of services and transitioning to available school related services as appropriate.

Training & Conferences

- Oxnard Region leadership attended the Southern Counties Regional Partnership (SCRP) Conference: "Transforming Together: Culturally and Linguistic Responsiveness Conference. on Sep 15-16. This conference provided best practices in a collaborative environment, better understanding of difficult to engage populations, and awareness of common biases of practitioners.

Substance Use Services (SUS) Division:

Prevention

Responding to Fentanyl and Naloxone Training for Schools

- Over the last 60 days, media reports of accidental overdoses in Southern California, including a fatal Fentanyl OD on school grounds in Los Angeles, and the DEA announcements about "rainbow fentanyl" have fueled intense interest in prevention and overdose response efforts.

- In collaboration with local districts, Prevention Services has already begun implementing staff development training, supporting school nurses from multiple districts, as we expand our "Institutional Kit Program." Schools can get assistance, help with training, and OD rescue kits.
    - VCBH anticipated potential need and has sufficient supply to help local schools.
    - Training is carried out in coordination with a Health Administrator or School Nurse for each site.
    - With our contractor GiveAnHour, we have already started supporting multiple school sites.
    - Each rescue kit issued contains two (2) doses of nasal naloxone in a labeled container similar to a small first-aid case [with visual instructions].
    - Kits are issued AFTER sites have policy in place, standing order secure, and training completed.
    - When a rescue kit is used in a suspected overdose event, they can be replaced within 48 hours.

- VCBH urges parents and community members to be vigilant, *but NOT to panic*. Although brightly colored drugs which contain fentanyl are a legitimate risk for accidental ingestion, we do not have evidence of widespread use among local teens currently.

FEATURED: "Fake Pills, Real Danger" Prevention Campaign

- We are running a campaign with the line, "Fake Pills, Real Danger" (see attached) and suggest using recent stories as an opportunity to have honest and open dialogue with youth about the dangers of using drugs and the extreme risks of taking any pill that was not prescribed for them.
- Because of the great collaboration with Public Health and school nurses countywide, we are in position to help ensure Districts who want support and supplies can respond with naloxone according to their District policy.

    - For more information, visit www.VenturaCountyResponds.org or call 805-667-NO-OD (6663).

Administration:

CalAIM

- The CalAIM unit (California Advancing and Innovating Medi-Cal) continues to coordinate CalAIM efforts across the department. A CalAIM dedicated team, which includes managers from various functional areas, continues to meet on an ongoing basis to provide technical assistance to providers regarding the policy changes that went into effect on 07/1/22. Since July 1st, the CalAIM team has held weekly CalAIM office hours for staff and contracted providers to address any CalAIM-related questions. Additionally, VCBH staff and contracted providers recently received a FAQ document of CalAIM questions that have been collected through the CalAIM implementation process to help provide answers to commonly asked questions. The CalAIM team will continue to provide technical support in a variety of ways to both staff and contracted providers.

- VCBH is currently attending weekly CalMHSA's Semi-Statewide Shared EHR "Kick-Off" meetings for the counties participating in the "Phase I" implementation phase. On-going communication and collaboration with contracted county partners and the local managed care health plan continue to help facilitate a smooth implementation experience.
- Over the past few months, the CalAIM unit has been focused on the CalAIM Behavioral Health Quality Improvement Program (BHQIP). The BHQIP program is an incentive payment program to support Mental Health Plans (MHP), Drug Medi-Cal State Plans (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) (also referred to as County Behavioral Health Plans) as we prepare for changes in the California Advancing and Innovating Medi-Cal (CalAIM) initiative and other approved administration priorities. VCBH can earn incentive payments in the CalAIM BHQIP by completing deliverables tied to program milestones. VCBH submitted the first BHQIP submission report to DHCS on September 29th.

Facilities, Safety & Disaster

- Continued compliance efforts related to Cal/OSHA and CDPH COVID prevention and response. Conducting program moves to address new program space needs and increasing staff size. Working on department vehicle use and pool options to better provide accessible transportation and increased utilization of department vehicles. Assisting with development of possible new service facility in Ventura in coordination with VUSD. Preparing to implement new workplace violence prevention training program. Beginning annual code grey drill training program this month. Safety training component for new Clinic Administrators in coordination with the Adult Division starts this month. Added a heat illness prevention plan and training to the department's IIPP. Reviewed and updated the department's annual health and safety training. Updated the department's continuity of operations plan (COOP). Preparing for end of the year fire drills at all BH locations.

Contracts Team

- FY 2022-23 Contractor site reviews continue to be scheduled for mental health Medi-Cal providers that are new this fiscal year and for SUS treatment Medi-Cal providers. Fall Provider Meetings, to monitor provider performance, are scheduled to begin at the end of October and run through first week of December. Contracts will be completing a site review of the Vista Del Mar facility in November. Contracts Management training is being offered to VCBH staff in October to assist staff in understanding the procurement regulations and how to properly manage their assigned contracts.

Quality Assurance

- **CalAIM:** QA/Training has continued to support VCBH training on implementation of CalAIM documentation reform. Office hours and FAQs provide clarification and ongoing support.
- **VCBH Policy Office** continues to create and update policies, procedures, and operational guidelines to operationalize implementation of DHCS BH Information Notice and CalAIM integration.
- **Utilization Review** conducts quarterly reviews and administrative exit reviews. In alignment with CalAIM changes, the focus is on identifying and remediating inaccurate billing, and provision of guidance and training to improve the quality of clinical documentation, along with ongoing identification of instances of Fraud, Waste and Abuse.

- **QA** facilitates provider credentialing and Medi-Cal site certification and is currently working on the creation of operational guides and flow charts to memorialize and standardize protocols.
- **Mentored Internship Program (MIP):** VCBH has been granted a one million dollar grant to enhance the professional development of diverse talent to help meet California's urgent need for BH workforce in the near-term, expand California's future BH workforce, and develop ongoing partnerships between BH organizations and local educational institutions. All 12 students have been placed and paired with VCBH mentors who participate along with educational partners in learning collaboratives to enhance professional learning.

Quality Improvement

- In FY 2022-23, the Mental Health and DMC-ODS external quality reviews will take place at the same time November 8th-10th. This is the first joint, or side-by-side review, and plans are underway. The agenda is being finalized and invitations will be sent out as soon as possible.
- QI now has 5 performance improvement projects (PIPs) that address various areas for improvement. The initial plans for 3 new PIPs specific to CalAIM-related shifts in measuring specific items to follow-up after an emergency room visit and adherence to Medication Assisted Treatment (MAT) were recently submitted and implementation will begin soon. One current PIP is continuing, and one new PIP is in development.
- 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. The initial phase of development will be completed soon, with further metrics added in the future.
- The Quality Management Action Committee (QMAC) had an all-group meeting on September 15th, allowing various stakeholder to participate in data review and discussions. In addition to large group meetings, smaller work groups will be regularly convened. QI continues to recruit consumer/family/peer and community stakeholders for the QMAC. Names can be sent to vcbh.quality@ventura.org
- To support VCBH Strategic Plan efforts, QI has analyzed and prepared baseline data that will be used to monitor and report progress. For key outcomes that do not yet have baseline data, QI will be working with department leads to develop methods for future reporting.

Electronic Health Record

- CalMHSA EHR
    - The Kickoff for the CalMHSA EHR Implementation began on September 7th. The goal of this project is the replacement of the Netsmart Avatar EHR with a CalMHSA provided EHR named SmartCare. The current project phase is focused on the understanding of new system features and how they will be reflected in daily clinical and administrative operations. This process will also reveal any gaps, if any, in features between the existing and new EHR applications.
- CalAIM Documentation Reform
    - Current CalAIM efforts are focused on implementing Standardized Screening Tools and Standardized Transition of Care Tools. Both new tools are scheduled to be active on January 1, 2023.

- Opeeka P-CIS
    - The implementation of P-CIS, the Youth & Family CANS Assessment Analysis Tool continues. Most CANS data have been successfully securely imported into P-CIS: a vendor-hosted System developed by Opeeka. Current efforts are focused on developing a Daily Update process to export recently updated CANS data to the P-CIS environment.
- FSP Client Key Event Tracking
    - The MHSA Data Coordination Project implementation continues. The purpose of this system is to collect Key Event notifications pertaining to the Full-Service Program (FSP) client population group. Currently, notifications are received from the VCMC and Santa Paula hospitals regarding Emergency Room visits. Future notification services will include Law Enforcement engagements and Homeless system (HMIS) interactions for this client population. The goal of this initiative is to provide timely notice to clinicians treating the FSP client community regarding client interactions with in-scope Key Event Incidents.

Which one is fake?

One of these pills has a deadly amount of fentanyl.

Fake pills. Real danger.

Find out which at:
FentanylVenturaCounty.org

NØ
OD

VENTURA COUNTY BEHAVIORAL HEALTH

Clients Served

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

As of 10/6/2022

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	**11,513**	**1,111**	**5,878**	**3,954**	**924**	**509**	**29**	**58**

**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	2,825	32		2,577	280	60		
16-25	2,283	200	807	1,194	205	97	8	11
26-59	5,082	834	3,869	183	382	274	18	46
60+	1,323	45	1,202		57	78	3	1
Grand Total	**11,513**	**1,111**	**5,878**	**3,954**	**924**	**509**	**29**	**58**

**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	9,859	1,037	5,077	3,256	806	462	28	55
Spanish	1,115	62	525	464	91	30	1	3
Mixteco	4	1	1	2	1			
Non-Threshold Language	78	1	63	12	2	3		
Not Reported	457	10	212	220	24	14		
Grand Total	**11,513**	**1,111**	**5,878**	**3,954**	**924**	**509**	**29**	**58**

**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	5,983	616	2,649	2,536	483	155	10	23
Non-Latinx	4,011	407	2,686	779	277	181	19	33
Not Reported	1,512	87	539	638	163	173		1
Declined to State	7	1	4	1	1			1
Grand Total	**11,513**	**1,111**	**5,878**	**3,954**	**924**	**509**	**29**	**58**

**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	448		94	354				
FILLMORE	176	35		144				
MOORPARK	11			11				
OXNARD	6,145	854	2,657	1,688	924	509		
SANTA PAULA	854		571	283				
SIMI VALLEY	1,311	80	732	521				
THOUSAND OAKS	1,272	58	936	298				
VENTURA	2,185	75	1,120	1,015			29	58
Outside Ventura County (Contractor)	166	142	24					
Grand Total	**12,568**	**1,244**	**6,134**	**4,314**	**924**	**509**	**29**	**58**

*** Clients may be counted under multiple locations

**VCBH enrolled clients only

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	**963**	**86**	**562**	**241**	**73**	**61**	**3**	**2**
Conejo Valley-Newbury Park	243	27	135	64	26	8	1	
Conejo Valley-Oak Park	30	1	7	19	1	4		
Conejo Valley-Thousand Oaks	643	56	392	147	42	46	2	2
Conejo Valley-Westlake Village	47	2	28	11	4	3		
Moorpark	**343**	**22**	**137**	**166**	**26**	**14**		**1**
Moorpark	343	22	137	166	26	14		1
Ojai	**220**	**17**	**102**	**77**	**18**	**15**		**1**
Ojai	167	15	83	48	15	15		1
Ojai-Oak View	53	2	19	29	3			
Oxnard Plains	**5,108**	**492**	**2,614**	**1,802**	**398**	**187**	**7**	**20**
Oxnard Plains-Camarillo	778	49	449	250	23	45	1	2
Oxnard Plains-Oxnard	3,950	399	1,988	1,399	351	123	6	16
Oxnard Plains-Port Hueneme	359	43	166	146	22	18		2
Oxnard Plains-Somis	21	1	11	7	2	1		
Santa Clara Valley	**1,155**	**91**	**486**	**531**	**81**	**40**	**2**	**8**
Santa Clara Valley-Fillmore	345	34	137	157	25	12	1	2
Santa Clara Valley-Piru	40	2	14	22	4			
Santa Clara Valley-Santa Paula	770	55	335	352	52	28	1	6
Simi Valley	**1,338**	**121**	**655**	**484**	**116**	**75**	**4**	**4**
Simi Valley	1,338	121	655	484	116	75	4	4
Ventura	**2,062**	**245**	**1,166**	**554**	**192**	**96**	**13**	**18**
Ventura	2,062	245	1,166	554	192	96	13	18
Not Reported	**324**	**37**	**156**	**99**	**20**	**21**		**4**
Not Reported	324	37	156	99	20	21		4
Grand Total	**11,513**	**1,111**	**5,878**	**3,954**	**924**	**509**	**29**	**58**

Residence cities do not reflect client service location.

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EHR Multi-County Innovation (INN) Project

Appendix and Budget Template – Guidelines

APPENDIX: VENTURA COUNTY

1. **COUNTY CONTACT INFORMATION**

Project Lead: Scott Gilman, MSA, VCBH Director, Scott.Gilman@ventura.org
Secondary Project Lead: Dr. Loretta Denering, Dr. PH, MS, VCBH Assistant Director, loretta.denering@ventura.org
Information Systems (I.S.) Project Leads – Dave Roman, Manager, Electronic Health Record Systems, Dave.Roman@ventura.org

2. **KEY DATES:**

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	*09/19/22 -10/17/2022*
Public Hearing by Local Mental Health Board	*10/17/2022*
County Board of Supervisors' Approval	*11/1/2022*

This INN Proposal is included in:

	Title of Document	Fiscal Year(s)
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	*FY 21-22*
X	Stand-alone INN Project Plan	FY 22-25

3. **DESCRIPTION OF THE LOCAL NEED(S)**

Existing Electronic Health Records (EHR) impacts the delivery of Behavioral Health Community Services due to the time involved in documentation. It is estimated that 40% of healthcare staff time is spent on this activity instead of providing essential direct care services. The community has expressed their frustration with not having more immediate access to care due to high caseloads and crucial demand for

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behavioral health services. Direct staff also relayed how they are impacted by stress and burnout due to the high demands of the work and the excessive amount of time spent on documenting within the existing EHR, versus spending time on direct client care.

Additionally, the COVID-19 pandemic has increased the demand for behavioral health services, has disproportionally impacted communities of color, and is a major factor contributing to the workforce shortages the County is currently facing. The existing EHR system is not designed in a manner that efficiently serves the community or behavioral health employees.

California Advancing and Innovating Medi-Cal (CalAIM) has created the need for an EHR that can meet the new CalAIM goals, standards, and outcome measure requirements. Specifically, to be compliant with the CalAIM requirements, a re-design of the EHR is needed that includes payment reform, data exchange, and the mandated use of new measurement tools and outcome measures and new billing protocols by California Behavioral Health programs.

Ventura County Behavioral Health's (VCBH) existing EHR system is not designed to address all the above noted concerns. Specifically, the VCBH EHR: (1) workflow is disruptive to client care, (2) increases user burden and stress, (3) does not provide essential outcome criteria, (4) does not have mechanisms in place to easily identify the need to transition clients to the most appropriate services based upon their current need, (5) requires a significant amount of time to input information into the EHR is not necessarily meaningful to the clients or staff, and (6) would not meet the CalAIM requirements.

Below is a list of the direct feedback from community, contractors, and staff that utilize the current VCBH EHR system:

- Stakeholders expressed frustration with duplicative data entries throughout the current EHR system. For example, a diagnosis must be entered in each client episode rather than for the client's file.
- Double entry is required for some of the largest contracted agencies since current EHRs do not talk to each other.
- Current system does not have an active client portal for clients to immediately see their records to manage their care. Instead, clients must make a formal request to receive a copy of their records and wait for receipt of those records to inform their decision making.
- Data and reporting stakeholders described frustration with the fact that a third-party application is needed to design and automate ongoing reporting and data entry analysis.
- Accessing the current EHR is expensive especially for a new or large contractor to get set up.
- EHR entry and pulling data can take substantial time to process and load reports, sometimes up to twenty (20) minutes for a routine report.

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- Client data is currently episodic so tracking the most up to date challenges or problems that a client is experiencing can be difficult. Often, staff have to dig through multiple tabs to ensure they know what the most pressing issues are for a client.
- The episodic set up can also mean that an important client update does not have a specified place in the record if it is not directly related to the current client episode.

4. **DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY**

Ventura County's highest priorities are client care and addressing the needs of our community. By joining CalMHSA in creating a new Semi-Statewide Enterprise Health Record, using Streamline Healthcare's SmartCare platform, VCBH can do both. The new EHR will be more person and provider centered, services can be enhanced by decreasing the amount of time (estimated 30%) providers are required to document. The project will include a robust process of input from participant counties to ensure the system will allow VCBH stakeholder feedback to be incorporated and for staff to have additional time to provide enhanced services to the community.

This multi-county collaborative will capitalize on the strength, knowledge, and experiences of over twenty (20+) counties in formulating a new EHR. The new EHR will meet the new CalAIM standards and will quickly adapt to the ever-changing State requirements. Additionally, it will allow staff to collect and report on meaningful outcomes and provide tools for direct service staff that enhance rather than hinder care to the clients they serve.

This is an opportunity for Ventura County to benefit from this larger collaborative bringing expertise, knowledge, and experience to this project under CalMHSA's leadership and the Behavioral Health Counties participating in this project. This project is highly Innovative due to this unique opportunity to create a new EHR in the above manner. The County will have the ability to participate in an evaluation of the project inclusive of stakeholder perceptions of and satisfaction with the decision-making process, as well as formative assessments to iteratively improve the design and usability of the new EHR by utilizing Human-Centered Design approaches that include summative assessments of the user experience and satisfaction with the new EHR as compared to the existing EHR and user burden. Below is a list of local stakeholder feedback on ideal EHR project goals:

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- "Psychiatric Advanced Directives (PADs) should be integrated into the new EHR". Currently staff must dig through uploaded documents in the client record to even know if they have one completed.
- "I think we're very behind on this front, I'd like to see parody with the medical health records system. I shouldn't have to explain my experiences to every new clinician. Retelling my history can be retraumatizing."
- Patient access is a key component. The client and the treating provider should agree on what has transpired in treatment and on the treatment which is planned. As Pat Deegan established, there must be common ground between the client and the practitioner for shared decision making to be successful.
- "Clients should be able to have an active role in their care, direct conversations with their doctor."
- There should be a way to summarize the critical issues that a client is experiencing, especially for clients who have been in treatment for many years.
- Treatment planning takes place together, the client should be able to see what the clinician is documenting.
- "I think it's essential to match our records system to the social determinants of care. I want to know if a client is living in a food desert or doesn't have access to public transportation, these things shouldn't just be in the assessment but should be highlighted in the record so I can treat the person and I can understand the circumstances they are impacted by."
- Better identification of primary language for a client as well as tracking if their session took place with a bilingual clinician of if an interpreter was needed.
- One stakeholder discouraged using innovation funding noting it should be used for community treatment and care not software design.
- Design the system to align across the participating counties and based on DHCS requirements – less variation in the data being captured will allow for state reporting to be competed more easily.
- Built in analytics (that can be customized) to save staff time across counties from creating and monitoring the development of data required by the state.
- Demographic data that matches the Counties populations as well as State and Federal guidelines.

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5. **DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS**

The proposed statewide EHR project was originally presented as a possibility resulting from changes being made through CalAIM during the community planning process of November 2021. At that point it was not yet decided if the project would utilize Mental Health Services Act (MHSA) Innovation funding. Later in the year pursuit of the project began in earnest and included going to the Board of Supervisors with a CalMHSA Participation Agreement and was included in the County's MHSA 21-22 Annual Update. At that time with few details, the project was listed as being planned for an INN project which also went through a thirty (30) day public comment period and was reviewed in the Behavioral Health Advisory Board (BHAB) meeting held on May 16, 2022. The participation agreement was also reviewed by the BHAB at the August 15th, 2022, board meeting. A department wide survey took place as a part of the larger project planning process though CalMHSA and locally a series of nine (9) key stakeholder interviews took place from August - September 2022 and a public discussion took place at the Adult BHAB subcommittee meeting on September 1, 2022.

The Local review process began September 19th, 2022, with the INN project brief and Ventura County Appendix being posted for the thirty (30) day public posting. The Public hearing is planned for October 17th, 2022, and the Board of Supervisors' approval is calendared for November 1st, 2022

During the interview process and at the public meeting two (2) questions were asked: What drawbacks do you feel currently exist with the existing EHR system and what would your ideal EHR system entail? Responses have been summarized in the sections above.

Sustainability Plan

The initial innovation component of the Semi-Statewide Enterprise Health Record project will primarily be funded with MHSA INN funds. The non-innovation and subsequent cost component of this project (which is majorly the on-going subscription costs for EHR contract) will primarily be funded by MHSA CSS funds, which is expected to take place in the first year. It is estimated that MHSA CSS funds will cover 70% of the cost and Short Doyle Medi-Cal Federal Financial Participation (SD/MC FFP) and other funding will be leveraged to help cover the cost of the remaining 30% moving forward.

6. **CONTRACTING**

CalMHSA will be the lead agency collaborating with twenty (20)-plus (+) counties on this project who will participate in the various stages involved in designing, implementing, and evaluating the new EHR. Ventura

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County has engaged in a contract with CalMHSA and will fully participate in the development of the Semi-Statewide EHR project. CalMHSA will serve as the Administrative Entity and Project Manager.

Ventura County will provide project management, data analysis, technical support, regulation compliance and ensure ongoing stakeholder input throughout the project though the following staff resources:

- VCBH Director and Assistant Director
- MHSA Innovations Program Administrator
- Manager over current Electronic Health Records Department
- Contracts Administrator

7. COMMUNICATION AND DISSEMINATION PLAN

Communication for this project will be provided through regular MHSA BHAB meeting updates as well as MHSA webinar updates. Stakeholders will have the opportunity to ask questions, provide feedback and comments.

Ventura County will be part of the ongoing stakeholder process from inception to completion, including research conducted by RAND (a non-profit research organization) who will conduct formative assessments of the user experience during the design, development, and pilot implementation phases, including post-implementation assessment of key indicators such as time spent completing tasks, cognitive load/burden, and satisfaction. These reports will be posted to the VCBH website, Wellness Everyday, and as a part of the Annual Update or three (3) Year Plan.

Annual updates will report on the ongoing local process towards the project's learning goals, with a final report submitted to the State at the project's conclusion. Ongoing presentation updates will be provided to the BHAB annually.

Ventura County staff will participate at each level of this project, providing ongoing feedback, piloting of program, and completing surveys, and conducting assessments of the new EHR as outlined by RAND.

Information about the MHSA EHR innovation project could be found by going to:
https://www.wellnesseveryday.org/mhsa/innovation-projects
https://www.saludsiemprevc.org/mhsa/proyectos-de-innovacion

https://www.vcbh.org/en/about-us/mental-health-services-act
https://www.vcbh.org/es/sobre-nosotros/mental-health-services-act

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8. **COUNTY BUDGET NARRATIVE**

Ventura County is requesting to spend up to $2,948,980 of MHSA Innovation funding for this project over a period of three (3) years. Additionally, Ventura County is also estimating that it will use $315,930 of SD/MC FFP and $250,000 in other funding (Behavioral Health Quality Improvement Program (BHQIP)/MHSA Community Supportive Services). The total cost for the innovation portion of this project is estimated at $3,514,910.

Personnel		
Senior Program Administrator (Billing team)	0.5 FTE will perform testing, data validation, and review testing result from the billing perspective as part of the implementation of the new EHR system.	$62,338
Program Administrator III (Billing team)	0.5 FTE will perform testing, data validation, and review testing result from the billing perspective as part of the implementation of the new EHR system.	$55,067
Accounting Assistance (Billing team)	0.5 FTE will perform testing, data validation, and review testing result from the billing perspective as part of the implementation of the new EHR system.	$28,872
BH Manager II (E.H.R. IT team)	0.5 FTE will provide configuration and technical support of the implementation process.	$69,968
Program Administrator III (E.H.R. IT team)	0.75 FTE will provide configuration and technical support of the implementation process.	$84,428

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Accounting Manager II	0.5 FTE will oversee and manage the data review and validation from the finance perspective.	$74,006
Senior Program Administrator	0.5 FTE will oversee and manager the implementation process with vendor and county staff.	$60,904
Behavioral Health Clinician IV	0.75 FTE will test the new system from the end user's perspective.	$67,907
Payroll Taxes and Benefits (Direct Cost)		$254,448
Operating Expenses – Direct Cost		
Communication Expenses	*Cost for voice, data, internet*	*$8,533*
Office Expenses	*Cost for office supplies and printing*	*$2,322*
Computer Equipment	*Cost for laptops, monitors, and miscellaneous computer equipment*	*$5,688*
Training	*Cost for training and conference*	*$627*
Office Leases	*Allocation of office leases*	*$22,530*
Consultant/Contract Expenses		
CalMHSA Contract	Project implementation and development cost for 2 years (performed by Streamline Healthcare Solution)	$2,097,626
Evaluation Costs		
CalMHSA Contract	Project evaluation cost (performed by RAND)	$500,000
Indirect Costs		
Indirect Cost	15% of Personnel and Operating Expense (Direct Cost)	$119,646
Total Budget		***$3,514,910***

9. **BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY**

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Please see attached excel file.

10. **TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR**

Please see attached excel file.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: ***Ventura County***

EXPENDITURES

	PERSONNEL COSTS (salaries, wages, benefits)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Salaries	245,605.0	257,885.0	-	-	-	503,490.0
2	Direct Costs (Benefit)	124,121.0	130,327.0	-	-	-	254,448.0
3	Indirect Costs (15% of Salaries and Benefit)	55,459.0	58,232.0	-	-	-	113,691.0
4	**Total Personnel Costs**	**425,185.0**	**446,444.0**	**-**	**-**	**-**	**871,629.0**

	OPERATING COSTS*	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
5	Direct Costs	19,366	20,334	-	-	-	39,700
6	Indirect Costs (15% of Direct Cost)	2,905	3,050	-	-	-	5,955
7	**Total Operating Costs**	**22,271**	**23,384**	**-**	**-**	**-**	**45,655**

	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**	0	0	0	0	0	$ -

	CONSULTANT COSTS/CONTRACTS	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
11	Direct Costs	2,211,472	236,154	150,000	-	-	2,597,626
12	Indirect Costs						-
13	**Total Consultant Costs**	**2,211,472**	**236,154**	**150,000**	**-**	**-**	**2,597,626**

	OTHER EXPENDITURES (explain in budget narrative)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
14							0
15							0
16	Total Other Expenditures	0	0	0	0	0	$ -

	EXPENDITURE TOTALS	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
	Personnel (total of line 1)	245,605	257,885	-	-	-	503,490
	Direct Costs (add lines 2, 5, and 11 from above)	2,354,959	386,815	150,000	-	-	2,891,774
	Indirect Costs (add lines 3, 6, and 12 from above)	58,364	61,282	-	-	-	119,646
	Non-recurring costs (total of line 10)	-	-	-	-	-	-
	Other Expenditures (total of line 16)	-	-	-	-	-	-
	TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	**2,658,928**	**705,982**	**150,000**	**-**	**-**	**3,514,910**

	CONTRIBUTION TOTALS**	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
	County Committed Funds	2,658,928	705,982	150,000	-	-	3,514,910
	Additional Contingency Funding for County-Specific Project Costs						-
	TOTAL COUNTY FUNDING CONTRIBUTION	2,658,928	705,982	150,000	-	-	3,514,910

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INNOVATIVE PROJECT PLAN

Section 0: Multi-County Innovative Project Plan Participants

PROJECT TITLE:
Semi-Statewide Enterprise Health Record (EHR) Innovation

PROJECT DURATION:
FY 22/23-FY26/27

PARTICIPATING COUNTIES AND OVERVIEW:
Currently, there are 23 California Counties participating in the Semi-Statewide EHR project. This project brings Counties together to implement the CalMHSA build of the Streamline Healthcare Solutions Behavioral Health EHR "SmartCare". One Pilot and two implementation phases are planned: the Pilot Phase (go-live January 2023) and Phase I (go-live July 2023), with a projected Phase II planned for July 2024. Three counties are going live with SmartCare in the Pilot Phase: Glenn, Imperial, and Lake, with these remaining 20 counties going live in Phase I: Colusa, Contra Costa, Fresno, Humboldt, Kern, Kings, Marin, Mono, Nevada, Placer, Sacramento, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Siskiyou, Sonoma, Stanislaus, Tulare, and Ventura. Together, these counties are responsible for close to 4,000,000 beneficiaries, or 27% of the statewide Medi-Cal population. Nearly 14,000 staff members in these counties rely on EHRs as a key tool for accomplishing their work in the provision of behavioral health services.
Of the above counties, eleven have expressed interest in participating in this Innovative Project Plan and are preparing appendices to this submission. This month we are submitting the appendices for the three counties that have completed their full Community Program Planning Process (CPPP) per MHSOAC staff guidance. We intend to submit the County-specific narrative and budget appendices for the remaining eight counties in the upcoming months as they complete their CPPP.

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 or supports or outcomes**
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM OR CHALLENGE

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county. NOTE: the Appendices for each County using INN funds for this Project provide the reason(s) why they have prioritized this Project.

The Mental Health Services Oversight & Accountability Commission (MHSOAC) has long been a key facilitator of investments in the California Public Behavioral Health System. These investments are tuned to deliver on the promise of the Mental Health Services Act (MHSA), which envisioned transforming an under-resourced safety net system into a holistic, well-functioning and responsive array of services to meet the current and emerging needs of California residents. The MHSOAC has

identified levers for enabling transformational change, many of which rely on robust technology and data systems. Of utmost importance among county data systems is the Electronic Health Record (EHR). These records are used to document and claim Medi-Cal services that County Behavioral Health Plans (BHPs) provide and, if properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities shouldered by BHPs.

California counties have joined together to envision an enterprise solution where the EHR goes far beyond its original purpose as a claiming system to a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system. We have identified three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce has to provide treatment services to our client population.
2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties are able to test and adopt innovative practices with reduced administrative burden.

Currently, EHRs fall short in several important ways. Cumbersome designs result in delays and inefficiencies in accessing and documenting the information needed to make sound clinical decisions. Sub-optimal configurations for data tracking and reporting, leading to use of external spreadsheets and add-on databases, contribute to difficulties in evaluating individual client progress, monitoring program outcomes, and meeting crucial state and federal reporting requirements. Additionally, limited interoperability solutions impede timely data exchange to support effective clinical processes and managed care business functions, such as care coordination and provider network management.

Until now, BHPs have had limited options from which to choose when seeking to implement a new EHR. The majority of EHR vendors develop products to meet the needs of the much larger physical health care market, while the few national vendors that cater to the behavioral health market have been disincentivized from operating in California by the many unique aspects of the California behavioral health landscape. This has resulted in the majority of county BHPs being largely dissatisfied with their current EHRs, while having few viable choices when it comes to implementing new solutions.

In addition to the data and outcomes limitations detailed above, EHRs have also been identified as a source of burnout and dissatisfaction among healthcare staff that provide direct service to those seeking care. EHRs, which were first and foremost designed as billing engines, have not evolved to prioritize the user experience of either the providers or recipients of care. The impact of this design issue is telling – an estimated 40% of a healthcare staff person's workday is currently spent in documenting encounters, instead of providing direct client care.

The pervasive difficulties of 1) configuring the existing EHRs to meet the everchanging California requirements, 2) collecting and reporting on meaningful outcomes for all of the county BH services (including MHSA-funded activities), and 3) providing direct service staff and the clients they serve

with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

Clearly, this current moment provides both the opportunity and the imperative for counties to take a substantial leap forward with regard to EHRs. BHPs are treating an expanded Medi-Cal population in an increasing amount of distress and are being asked to provide meaningful solutions for societal issues from homelessness to mental health impacts of COVID-19. The California Advancing and Innovating Medi-Cal (CalAIM) initiatives are requiring swift adoption of highly technical changes and transformation of County BH service delivery systems. Clinical documentation redesign, payment reform and data exchange requirements to bring California BH requirements into greater alignment with national physical healthcare standards, thereby creating a lower-barrier entry to EHR vendors seeking to serve California. At the same time, the COVID-19 pandemic has increased the demand for behavioral health services, has disproportionately impacted communities of color, and has factored into the staggering workforce shortages faced by counties throughout California. BHPs need to foundationally revamp their primary service tool to meet the challenges and opportunities of this moment. BHPs, in partnership with CalMHSA are positioned to do just that through the Semi-Statewide Enterprise Health Record initiative.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

This is a multi-county, scalable INN project that stems from a larger, Semi-Statewide Enterprise Health Record Project CalMHSA is concurrently leading (hereafter referred to the EHR Project). CalMHSA is currently partnering with 23 California Counties – collectively responsible for twenty-seven percent (27%) of the state's Medi-Cal beneficiaries – to join together as a Semi-Statewide Enterprise Health Record project. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future. The key principles of the EHR project include:

- Enterprise Solution: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County BHPs. This approach also facilitates data sharing between counties for patient's treatment and payment purposes as patients move from one county to another.
- Collective Learning and Scalable Solutions: Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk, and improving quality.
- Leveraging CalAIM: CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-

Cal claiming) while data exchange and interoperability with physical health care towards improving care coordination and client outcomes are being both required and supported by the State.

- Lean and Human Centered: CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- Interoperable: Typically, behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow so critical information about the people we serve is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

CalMHSA will serve as the Administrative Entity and Project Manager. Counties have previously participated in and provided robust input to CalMHSA during the collaborative learning phase that culminated in the Request for Proposal (RFP) seeking a new EHR vendor. Counties additionally participated in the EHR vendor selection process and will continue to provide their input throughout implementation of the EHR project.

Streamline Healthcare Solutions, LLC is the vendor selected for the development, implementation, and maintenance of the Semi-Statewide EHR.

As the Evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention. In addition, RAND will subcontract with a subject matter expert in the science of human-centered design to ensure the project is developed in a manner that is most congruent to the needs of the behavioral health workforce and the diverse communities they serve.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

This project will meet the general requirements by: making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision in an Electronic Health Record.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

This project aims to employ a human-centered approach to guide the development and rollout of a new EHR system that will be implemented by 23 or more County BHPs. Through the identification of challenges/shortcomings within existing (legacy) EHRs that contribute to key indicators of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County BHPs' workforce as well as the clients they serve.

Optimizing Health Information Technology procedures and technologies used by providers to meet their daily workflow needs can enhance working conditions, increase efficiencies, and reduce burnout, ultimately improving the conditions under which direct client care is provided. With the input of provider stakeholders and best practice experts in the field of human-centered design, the new EHR will be collaboratively and intentionally designed to improve the method and ease of documenting into the EHR as well as gathering pertinent clinical information from the EHR, which will promote less time spent on "treating the chart" and more time spent on "treating individuals" in need of care.

An editorial titled "Health information technology and clinician burnout: Current understanding, emerging solutions, and future directions", appearing in the Journal of the American Medical Informatics Association (JAMIA) published in March 2021 by Oxford University Press, the authors assert that "innovative solutions to prevent or mitigate burnout are urgently needed."

As noted in the Section below, also in the same JAMIA publication, is a documented example of using human-centered design being used effectively to improve the functionality of an EHR – in this instance, through the development of an application for use by Emergency Department physicians treating children with asthma-related conditions.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

This project focuses on transforming current EHR systems and processes counties utilize for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible to serve more than 27% California's Medi-Cal beneficiaries, or approximately 4,000,000 people.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

This project focuses on transforming the current EHR system and the processes California BHPs utilize for the provision of behavioral health services rather than directly testing an innovative approach to service delivery.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

This project will employ the Human-Centered Design (HCD) approach which is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is a critical component to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

Counties have attempted to adapt and/or develop workarounds to improve the functionality of their legacy EHRs, however, none have previously used the HCD approach to develop a new EHR.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

This Semi-Statewide Enterprise Health Record project will address gaps in the literature and existing practice by incorporating human-centered design processes to develop a new EHR system for California County Behavioral Health Plans.

The following are a few examples of the use of human-centered design processes in settings *other than* behavioral health:

1. "Human-centered development of an electronic health record-embedded, interactive information visualization in the emergency department using fast healthcare interoperability resources", published in March 2021 in the Journal of the American Medical Informatics Association. The research involved the development of The Asthma Timeline Application for use in the Emergency Department of the Children's Hospital of Philadelphia (CHOP), a large, academic, tertiary care children's hospital.
   https://academic.oup.com/jamia/article-abstract/28/7/1401/6157802

2. Health+™, pronounced "health plus," is a human-centered design and research model sponsored by the U.S. Department of Health & Human Services (HHS) to co-create solutions with—not for—people impacted by the most pressing healthcare challenges. The Health+ model positions people as active participants—experts in their own life challenges—listening and learning from their lived experiences, to uncover their needs and understand their challenges. Currently, the HHS team is running the first-ever Health+ effort to better understand Long COVID. Previously, HHS applied these human-centered design methods for sickle cell disease and Lyme and tick-borne disease. The Health+ model works best when applied to complex, multi-systemic, multi-disciplinary challenges with diverse stakeholder communities.
   https://www.hhs.gov/ash/osm/innovationx/human-centered-design/index.html

3. "Why Patients And Care Teams Should Co-Design Healthcare Technologies", a December 2019 Forbes post. The author states: "Technology designed for its own sake, rather than with the needs of workers in mind, is how we have ended up with too many healthcare technologies that complicate clinical workflows and turn many nurses and doctors into data entry clerks. The better approach is to observe users in their working environments, engage with them, understand their processes and needs, and see how they're connected to other people's jobs. Then, find the best, most efficient ways to improve their lives".
   https://www.forbes.com/sites/forbestechcouncil/2019/12/09/why-patients-and-care-teams-should-co-design-healthcare-technologies/?sh=58d8509bf4a7

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

EHR design and user experience have far-reaching impacts on individual treatment providers, treatment teams and provider/client relationships. These impacts range from the quality of the provider/client interaction to clinical outcomes and client safety. As a result, we are evaluating the impact of EHR design on:

Quality:

- Comprehensiveness of client care
- Efficiency of clinical practice
- Interactions within the health care team
- Clinicians' access to up-to-date knowledge

Safety/Privacy:

- Avoiding errors (i.e.: drug interaction)
- Ability to use clinical data for safety
- Personal and professional privacy

Satisfaction:

- Ease of use
- Clinicians' stress level
- Rapport between clinicians and clients
- Clients' satisfaction with the quality of care they receive
- Interface Quality

Outcomes:

- Communication between clinicians and staff
- Analyzing outcomes of care
- System Usefulness
- Information Quality

The pre-go live survey will establish which issues/task/workflows impact the above conditions and focus the human-centered design work on the highest-value items. Iterative design work will allow for cross-county learning that will inform the design of the new EHR. The post go live survey will measure how effectively we have addressed the identified EHR issues and our progress towards the goal of reducing documentation burden by 30%.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project will employ the Human-Centered Design (HCD) approach which is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is a critical component to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

OBJECTIVE I: Evaluate stakeholder perceptions of and satisfaction with the decision-making process
OBJECTIVE II: Conduct formative assessments to iteratively improve the design and usability of the new EHR
OBJECTIVE III: Conduct summative assessment of user experience and satisfaction with the new EHR versus existing EHRs and change in burden

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

CalMHSA will serve as the Administrative Entity and Project Manager, and Participation Agreements will be executed with each County. Streamline Healthcare Solutions, LLC is the vendor selected for the development, implementation, and maintenance of the Semi-Statewide EHR. As the Evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. See county-specific appendices for additional information.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

See county-specific appendices.

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: Each participating County will provide updates on the project to their Behavioral Health staff and community-based partners who are part of the Mental Health Plan as well as consumers and family members.

B) Cultural Competency: Each participating County convenes a Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians, and County staff. These committees will be informed on a regular basis as to the status of the project and will be invited to provide their input.

C) Client-Driven: The focus of the project is to improve the quality of specialty mental health and substance use services by improving the documentation input into the EHR, improving the communication between providers and teams, and improving timely access for consumers and clients.

D) Family-Driven: Families will have the opportunity to provide input into the project and will experience the improvement in the quality of services as well, as a part of improved communication efforts.

E) Wellness, Recovery, and Resilience-Focused: The project will include wellness and recovery outcomes and performance measures that are currently difficult to input or add to existing EHRs.

F) Integrated Service Experience for Clients and Families: If the project is successful in integrating the many required responsibilities and roles of BHPs, the ability to address the whole person's needs will be a measurable outcome. Referrals and linkages to other non-mental health providers will be easily tracked and reported to see where improvements can be made.

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

This project evaluation supports cultural competence and stakeholder involvement in evaluation in two crucial ways. Meaningful work towards improving the health outcomes of all beneficiaries relies on having accurate information on the treatment access and outcomes that can be analyzed by racial, ethnic and sexual orientation/gender identify variables. When BHPs report data regarding the clients they serve and the impact of services on the wellbeing of those clients, that data has been documented in and reported out of that BHP's EHR. By undergoing a design process which is built on

consensus decision-making guided by subject matter expert advice and grounded in current day best practices, the quality of the data available in the semi-statewide EHR and the ability to examine outcomes across a large swath of California will be significantly improved. From a direct service perspective, the total population of EHR end users (+/- 14,000 individuals) will have the opportunity to participate in the formative and summative assessments which will identify design, usability and satisfaction issues with the legacy EHRs and evaluate the new EHR along the same variables.

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 particular elements of the INN project without utilizing INN Funds following project completion.

Following project completion, participating counties will utilize other sources of funds to support the on-going maintenance of the newly developed EHR.

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.

This project focuses on transforming current Electronic Health Record system and processes counties utilize for the provision of behavioral health services.

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?*

See county-specific appendices

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.*

Human-Centered Design; Semi-Statewide Enterprise Health Record.

TIMELINE

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

Upon approval in Calendar Year 2022 through 6/30/2027.

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

Not to exceed five (5) years (FY22-23 through FY26-27).

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

A tentative project plan for the first eight quarters is available below. The project plan is expected to change and evolve as the multi-county innovation activities and learnings continue. CalMHSA and participating counties will convene at a minimum annually beyond the first eight quarters to examine and evaluate learnings and will continue to set goals during the project period.

FY 22/23	EHR INN Project Plan	Semi-Statewide EHR Project Plan: Pilot Phase	Semi-Statewide EHR Project Plan: Phase I
Q1 July - Aug	Consensus Gathering Landscape Analysis	Requirements Gathering	Requirements Gathering
Q2 Sept - Dec	Pre- Go Live Survey Period (Formative Assessment)	Analysis and Design Development/Configuration Testing/Training	Requirements Gathering
Q3 Jan - March	Human-Centered Design Process	Go Live	Analysis and Design
Q4 April - June	Human – Centered Design Process	Optimization	Development/Configuration Testing/Training
FY 23/24			
Q1 July - Aug	Design Optimization	Monitoring/Controlling	Phase I Go Live
Q2 Sept - Dec	Design Optimization	Monitoring/Controlling	Optimization
Q3 Jan - March	Post-Go Live Survey Period (Summative Assessment)		Monitoring/Controlling
Q4 April - June	Evaluation, Learnings and Recommendations		Monitoring/Controlling

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)*

See county-specific appendices.

APPENDICIES AND BUDGETS INCLUDED IN THIS SUBMISSION:

- Humboldt
- Sonoma
- Tulare

APPENDIX: HUMBOLDT COUNTY

1. **COUNTY CONTACT INFORMATION**

Oliver Gonzalez Bobadilla, MHSA Program Manager: Lead related to Innovation reporting
Scott Irvin, Medical Records Manager: Lead related to EHR implementation

2. KEY DATES:

Local Review Process	**Dates**
30-day Public Comment Period (begin and end dates)	May 25-June 23, 2022
Public Hearing by Local Mental Health Board	June 23, 2022
County Board of Supervisors' Approval	July 19, 2022

This INN Proposal is included in: (*Check all that apply*)

	Title of Document	**Fiscal Year(s)**
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	2022-2023
	Stand-alone INN Project Plan	

3. DESCRIPTION OF THE LOCAL NEED(S)

Humboldt County Behavioral Health has been experiencing challenges in hiring and retaining clinicians for the past several years. Our current vacancy rate for our clinician job classes is 33.7%. Since going live with the current EHR product in 2014 a frequent complaint by our clinical staff has been the difficulties associated with using that system. A common complaint has been that the system is "not intuitive," it is difficult to find information within the system quickly and that practitioners suffer from "click fatigue." There are significant limitations with making modifications to the existing system to improve upon these negative aspects. As a result, the current EHR has negatively impacted the overall job satisfaction of the practitioners and may be a contributing factor to workforce retention. The resolution of these issues will contribute to improving the workforce's job effectiveness, satisfaction and retention.

Behavioral Health staff feedback over the years has indicated that the user interface of the current EHR is not intuitive or user friendly. Required fields are not logically programmed leading to increased data entry errors. Database tables are not properly linked to one another so the same service information data must be entered in multiple locations. This is particularly problematic with updates to client information. The current EHR requires double and sometime triple entry into the progress notes with approval codes for missed and rescheduled appointments. This is an occurrence that happens every day for staff.

The scheduling calendar lacks the functionality of sorting by location, which makes appointments hard to track and causes double booking. The complexity of the scheduling calendar causes some staff to not use the function all together, which also creates the opportunity for appointments to be missed and fall through the cracks.

The current EHR does not possess a case load management system. This makes it extremely difficult to see who has interacted with the clients or who else is on a client's treatment team. This hinders communication and care coordination and causes duplicative efforts.

The current EHR requires significant administrative overhead to cover the deficiencies in the back end set up and lack of intuitive user reports. A new EHR that is more efficient to use should decrease the time documenting direct services and increase time spent providing direct services. It is anticipated that a new EHR will facilitate a client-centered approach that is founded upon creating and supporting a positive therapeutic alliance between the provider and client.

The current EHR is built on an archaic version of JAVA script which can no longer be updated. It means the software cannot be adapted to the everchanging hardware landscape such as tablets and portable devices, which would be more portable and user friendly. The JAVA script structure causes the software to be difficult to navigate, not ADA compatible and is practically illegible on portable devices.

There is currently no way to give community- based organizations (CBOs) access with the current EHR that would be compliant with our privacy and security practices. This makes sharing client information with our CBOs less streamlined and inefficient.

The structure of the current EHR also does not contain a patient portal. This prevents the county from adapting to the current digital landscape. It also prevents clients from having easy access to their digital record and prevents updating their client information efficiently. Many of the forms necessary must therefore still be completed on hardcopy, then entered into the system manually.

With the current roll out of California Advancing and Innovating Medi-Cal (CalAIM) by the Department of Health Care Services (DHCS), many changes are necessary in the EHR to be compliant with new requirements surrounding payment reform, documentation and policy updates, and data exchange. California Mental Health Services Authority's (CalMHSA) goal in working with Counties to roll out this semi-statewide collaborative EHR is to require the EHR to meet all regulatory requirements placed on Mental Health Plans (MHPs). Since multiple counties, with the same regulatory and clinical needs, will be participating in this collaborative EHR, it is likely that the vendor will be more diligent about making the needed changes.

4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY

Participation in this project is anticipated to increase direct mental health services by decreasing the time a provider spends in documenting encounters, thus addressing the learning goal of a projected 30% reduction in time spent documenting services. This will increase the time spent providing direct client care, addressing the learning goal of facilitating the achievement of a client-centered approach to service delivery founded upon creating and supporting a positive therapeutic alliance between the service provider and the client. The project is also anticipated to increase workforce satisfaction with their jobs. This meets the learning goal to improve California's public mental health workforce's job effectiveness, satisfaction and retention. In addition, this project will increase the efficiency and effectiveness of local data exchange, including through the Health Information Exchange, that is critical to support care of mental health patients in the Emergency Departments and with other service providers.

The information from the new EHR will be available for decision making on all levels and will support the efforts of the Humboldt County Behavioral Health Cultural Responsiveness Committee (BHCRC) in recommending system improvements to reach underserved communities.

Participating in this project was prioritized because it will meet a portion of the needs and challenges expressed by community and staff stakeholders as described in section 5 below.

Humboldt County will work with CalMHSA and the project evaluator to provide the information needed for the project evaluation.

5. DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS

Humboldt County's participation in this project will address some of the needs and themes expressed by community stakeholders during the last several years. In the community program planning process for the 2020-2023 Three Year Plan the top-ranking theme was to expand and increase mental health services and access to services. This was the second ranking theme in the 2022-2023 CPPP. The third-ranking theme for the 2020-2023 Three Year Plan was to increase support for the behavioral health workforce. This was the fourth ranking theme in the 2022-2023 CPPP. The participation in this project will contribute to expanding and increasing access to mental health services because staff will spend less time navigating an obsolete EHR and have more time to provide direct client care, thus increasing support for the workforce as well as increasing access to services.

Increasing bilingual and culturally competent services was also among the top needs identified in the 2020-2023 Three Year Plan and in the 2022-2023 Annual Update CPPP. One of the foundations of providing such services is having accurate data on what populations are underserved or unserved. This data has been difficult to obtain in the current EHR. The new EHR will provide more accurate data on these populations and help in planning for expanded services for them.

Stakeholder involvement. The CPPP for the 2022-2023 MHSA Annual Update began in August 2021 with the gathering of reports from MHSA program staff on the activities of

fiscal year 2020-2021 and updates on planned activities for 2022-2023. After the last of this information was received a draft Annual Update was written and dates were scheduled for regional and community meetings.

All information about meetings dates and other opportunities to participate in the CPPP was disseminated through the following avenues: DHHS Media issued a news release to fourteen media outlets, Facebook and Instagram; flyers and invitations were disseminated to several local distribution lists; and the announcements were posted on the County website and blog.

The draft Annual Update was presented at the quarterly MHSA Community Meeting in November 2021. This was a Zoom meeting attended by four individuals.

Regional meetings were scheduled in December 2021 and January 2022 for Southern Humboldt, Eel River Valley, Eureka, Eastern Humboldt and Northern Humboldt. Due to COVID-19, all meetings were scheduled and held via Zoom. A total of twelve individuals attended the regional meetings.

The MHSA Program Manager contacted community groups and organizations to ask for agenda time at their regularly scheduled meetings, or to request their assistance in setting up a special meeting to gather stakeholder input. In December 2021 and January 2022 three stakeholder meetings were held via Zoom with the Youth Advocacy Board, the DHHS/Education Leadership Team, and the Behavioral Health Board. A total of 47 individuals attended these meetings.

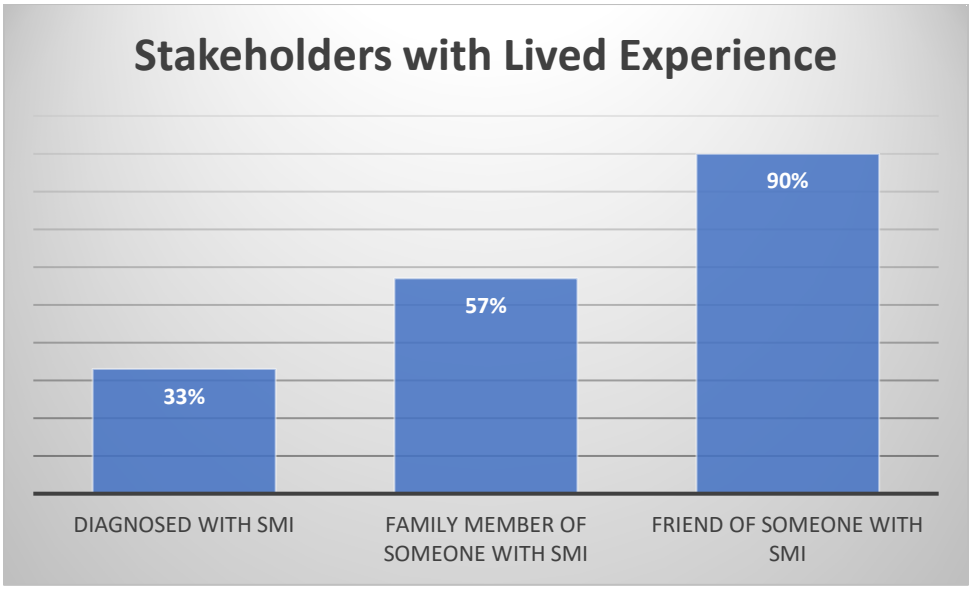
The results of the 2022-2023 CPPP and of the CPPP activities since the development of the Three Year Plan for 2020-2023 was presented at the quarterly MHSA Community Meeting in February 2022. This was a Zoom meeting attended by nine community members.

A total of 72 individuals attended stakeholder meetings during the 2022-2023 CPPP. Three stakeholders provided input through emails to the MHSA Comment Email address.

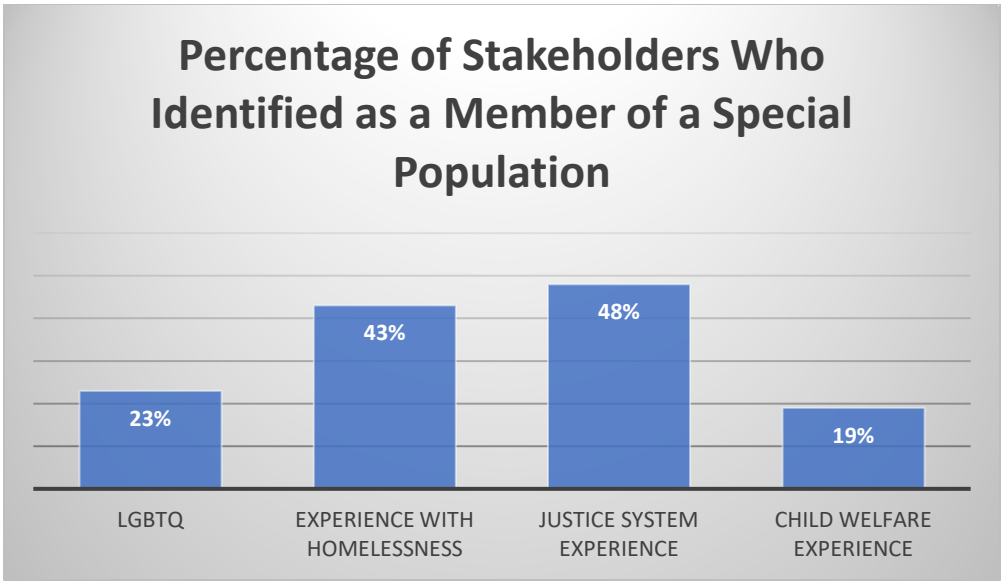
Stakeholder Demographics

Stakeholders attending meetings were asked to complete a MHSA demographic form. Completion of the form was voluntary, and responses were anonymous. A total of 22 individuals, 31% of those attending, completed a demographic form at the stakeholder meetings.

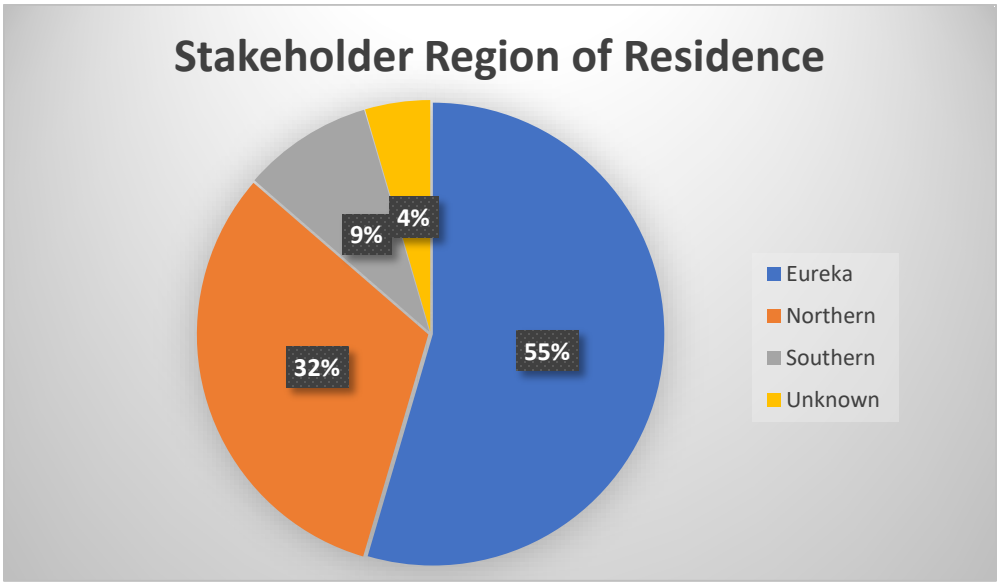
Individuals with lived experience of a serious mental illness (SMI) and their family members are a vital voice in the MHSA CPP. As seen in the chart below, 33% identified as having a mental illness, and 57% identified as a family member of someone with a mental illness. In addition, 90% of those attending the stakeholder meetings said they were a friend of someone with a SMI.



Additional life experiences have been identified as important voices for the CPPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPPP. Twenty-three percent identified as LGBTQ; 43% identified as having experience with homelessness; 48% had justice system experience; and 19% had Child Welfare experience. Because only one stakeholder stated their primary language was a language other than English this is not indicated on the chart.

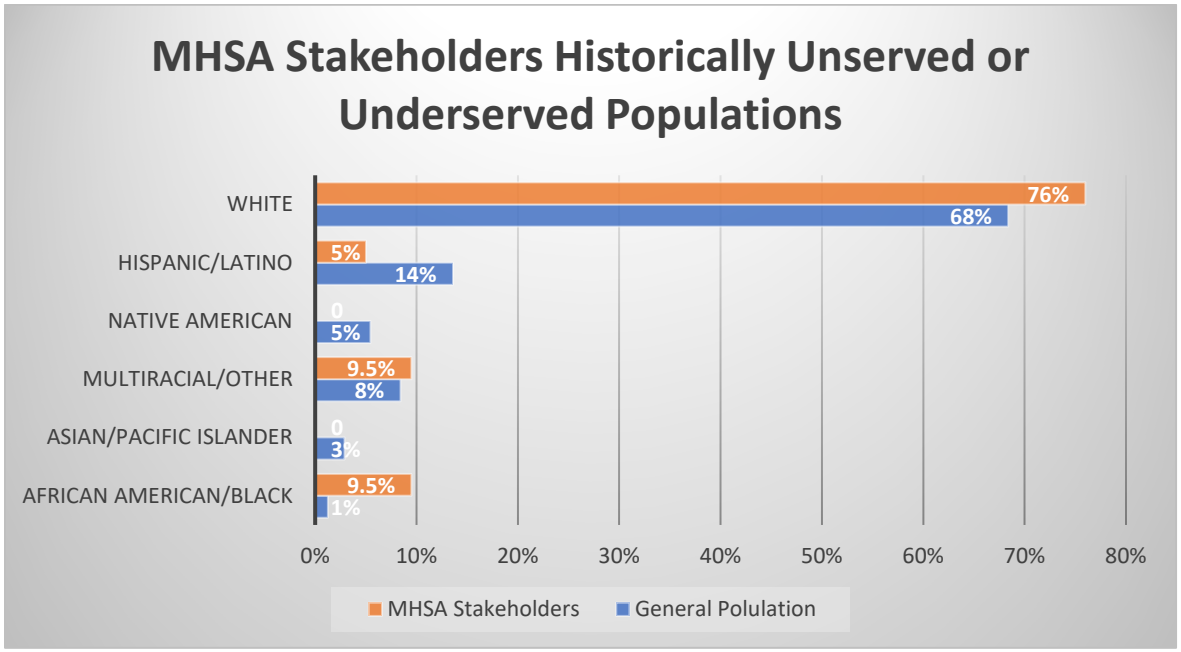


In these stakeholder meetings, 32% of participants resided in the Northern Humboldt region, which includes Arcata, Blue Lake, McKinleyville, and areas north, and 55% of participants resided in Eureka. Nine percent resided in Southern Humboldt, which includes Redway, Petrolia and Garberville. Four percent provided no answer. There were no attendees reporting their residence in the Eel River Valley or Eastern Humboldt.

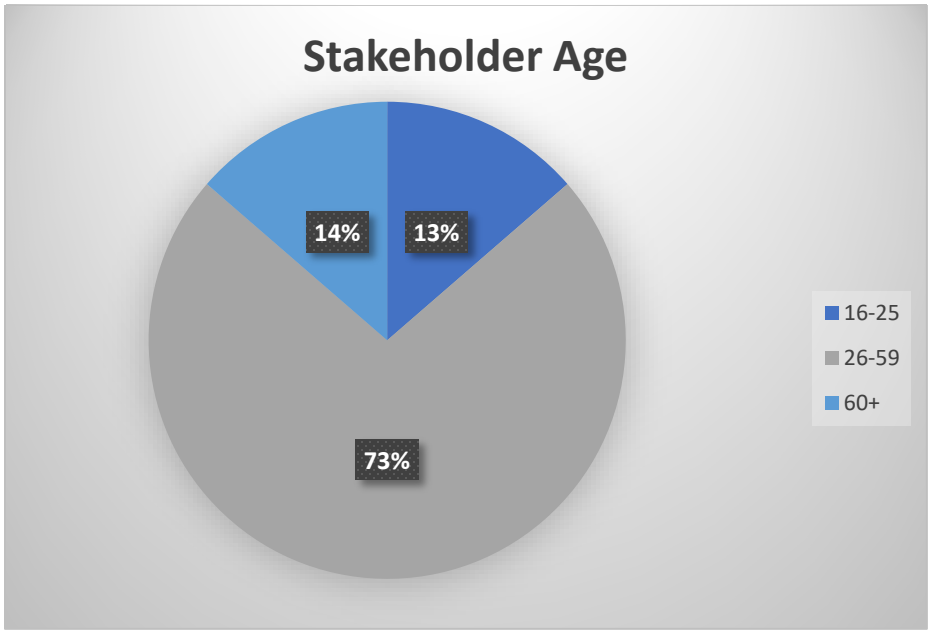


Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending stakeholder meetings, 5% were Hispanic/Latino as compared to 14% of the Humboldt County general population; 9.5% were Multiracial/Other as compared to 8% of the County general population; and 9.5% were

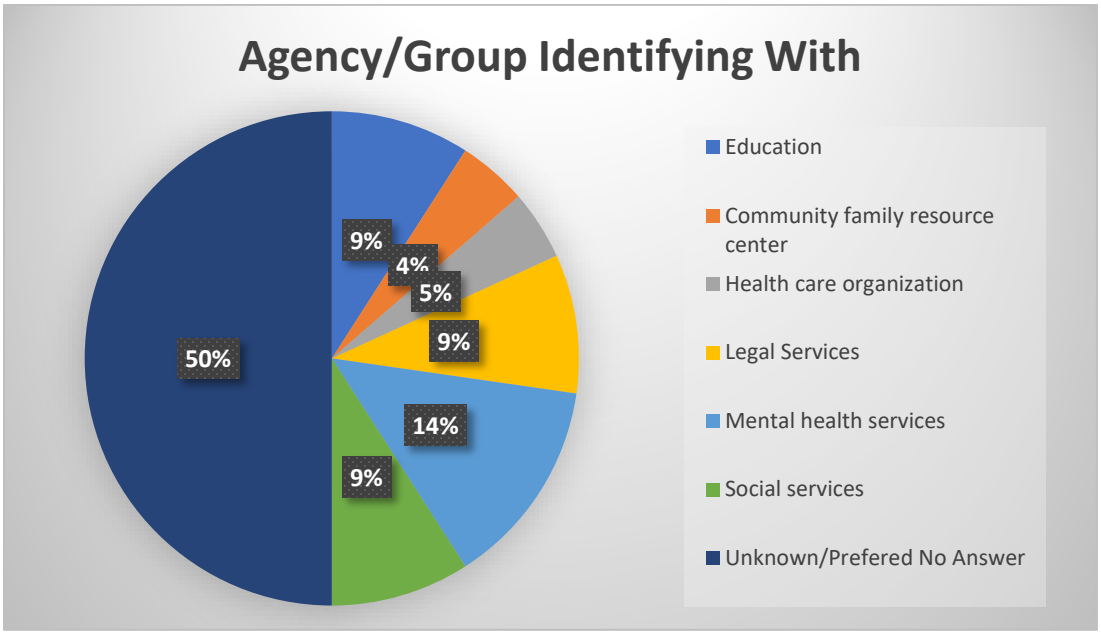
Black/African as compared to 1% of the general population. There were no Native American or Asian/Pacific Islander stakeholders completing the demographic form.



Thirteen percent of those completing the demographic form were ages 16-25; 73% were ages 26-59, and 14% were age 60+.



The chart below illustrates the representation from community agencies participating in the stakeholder meetings. It shows that the process included individuals from mental health services, 14%; education, 9%; health care organizations, 5%; social services, 9%; Community and Family Resource Centers (CRC/FRC), 4%; Legal Services, 9%. Fifty percent provided no response.



After the stakeholder meetings were completed, the notes from each meeting, comments on the demographic/comment form, and the comments received from the MHSA Email were reviewed. This review resulted in a grouping of comments and input by the overall themes/topics of the services and supports that community stakeholders would like to see more of, or changes within. These themes included increasing community input and engagement; expanding and increasing access to services; increasing support for the seriously mentally ill; increasing workforce education, support and training; increasing pregnancy and postpartum support; making facility Improvements; increasing bilingual and culturally competent services; increasing services for those experiencing homelessness; strengthening Substance Use Disorder Services; increasing investment in early childhood mental health services.

During the 30 day public comment period there were no comments made about the proposed Innovation project. At the Public Hearing hosted by the Behavioral Health Board on June 23, 2022, there was one question about the proposed Innovation project, and that question was to clarify that the project would be to replace the current EHR with a new EHR. When confirmed that this was the case, this individual expressed support.

Sustainability. Innovation funds will be tapped in fiscal year 2022-2023 for this project. Humboldt County anticipates an additional $666,170 from American Rescue Act grant funds for project years 2 and 3.

6. CONTRACTING

Humboldt County will be contracting with CalMHSA for this project. The BH Medical Records Manager is taking the lead on this project and will act as a liaison between the Mental Health Plan (MHP) and CalMHSA. We have a biweekly meeting where important EHR stakeholders meet to discuss, coordinate and approve projects tied to the EHR. This group includes BH Leadership (managers and deputies), Quality Improvement, Information Services, DHHS Quality Management, Claims Data Management, and Fiscal staff. This team will shift its focus to the rollout of the CalMHSA Semi-Statewide collaborative EHR by the July 1, 2023 go-live date and onward.

CalMHSA has started working with the MHP to identify points of contact regarding particular topics as we begin to engage in rollout. Our lead has provided CalMHSA with documents associated with our current processes and our current EHR. Moving forward we plan to engage the group listed above in ongoing discussions internally, using the biweekly meeting time and additional time as needed, and with CalMHSA as we work toward roll-out and maintenance thereafter. Each point of contact will also be utilized to share their expertise and to work with CalMHSA in establishing what it is we need from the Semi-Statewide Collaborative EHR.

7. COMMUNICATION AND DISSEMINATION PLAN

Quality Improvement uses Bulletins in order to communicate changes to our provider network, which includes BH staff and Organizational Providers. QI plans to release a bulletin to all impacted stakeholders regarding the transition to the Semi-Statewide Collaborative EHR and to update on any ongoing changes thereafter. QI also uses an e-learning system, called Relias, in order to track and train staff. Trainings will be built into Relias as needed along the course of rollout and maintenance thereafter. The MHP has adopted the CalMHSA Documentation Manual as our own and it has been indicated that for those counties opting into the collaborative EHR, there will also be an EHR guide. We plan on using resources developed by CalMHSA to train and/or communicate whenever applicable. Our biweekly stakeholder meeting will consist of discussions surrounding roll-out and ongoing efforts surrounding this new EHR and the minutes will reflect on results, successes, and lessons learned as we work through this project.

Information will also be communicated through quarterly MHSA meetings; the MHSA CPPP; through interim reports included in Annual Updates and Three Year Plans; through a final report in an Annual Update or Three Year Plan. These interim and final reports are posted to the County website at https://humboldtgov.org/430/Mental-Health-Services-Act-MHSA and shared with stakeholders through existing distribution lists.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: ***HUMBOLDT***

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						
7	**Total Operating Costs**						$
	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	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
11	Direct Costs	608,678					
12	Indirect Costs						
13	**Total Consultant Costs**	608,678					608,678
	OTHER EXPENDITURES (explain in budget narrative)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
14							
15							
16	Total Other Expenditures						$

	EXPENDITURE TOTALS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
	Personnel (total of line 1)						
	Direct Costs (add lines 2, 5, and 11 from above)						
	Indirect Costs (add lines 3, 6, and 12 from above)						
	Non-recurring costs (total of line 10)						
	Consultant Costs/Contracts (total of line 13)	608,678					608,678
	Other Expenditures (total of line 16)						
	TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	**608,678**					**608,678**

	CONTRIBUTION TOTALS**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
	County Committed Funds	1,062,134	353,721	312,458	312,742	313,034	2,354,087
	Additional Contingency Funding for County-Specific Project Costs						
	TOTAL COUNTY FUNDING CONTRIBUTION	1,062,134	353,721	312,458	312,742	313,034	2,354,087

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

COUNTY: ***HUMBOLDT***

ADMINISTRATION:

A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds	458,678	-	-	-	-	458,678
2	Federal Financial Participation	142,839	111,422	98,424	98,514	98,606	549,805
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	80,242	196,924	168,659	214,228	214,428	874,480
5	Other funding	230,375	45,375	45,375	-	-	321,125
6	Total Proposed Administration	912,134	353,721	312,458	312,742	313,034	2,204,088

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds	150,000					150,000
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Evaluation	150,000	-	-	-	-	150,000

TOTALS:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation(INN) MHSA Funds*	608,678					608,678
2	Federal Financial Participation	142,839	111,422	98,424	98,514	98,606	549,805
3	1991 Realignment						-
4	Behavioral Health Subaccount	80,242	196,924	168,659	214,228	214,428	874,480
5	Other funding**	230,375	45,375	45,375			321,125
6	Total Proposed Expenditures	1,062,134	353,721	312,458	312,742	313,034	2,354,088

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.

** If "other funding" is included, please explain within budget narrative.

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EHR Multi-County Innovation (INN) Project

Appendix and Budget Template – Guidelines

APPENDIX: **_SONOMA COUNTY**

1. **COUNTY CONTACT INFORMATION** (*who is your Project Lead, as provided to CalMHSA*)**:**

Name of Contact	Role	Email
Jan Cobaleda-Kegler	Behavioral Health Director	Jan.Cobaleda-Kegler@sonoma-county.org
Christina Marlow	QAPI Section Manager	Christina.Marlow@sonoma-county.org>
Melissa Ladrech	MHSA Coordinator	Melissa.Ladrech@sonoma-county.org

2. **KEY DATES:** (*Include actual dates and/or expected dates, as per your local timeline)*

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	June 20, 2022- July 19, 2022
Public Hearing by Local Mental Health Board	July 19, 2022
County Board of Supervisors' Approval	Scheduled for September 13, 2022

This INN Proposal is included in: (*Check all that apply*)

Title of Document		Fiscal Year(s)
X	MHSA 3-Year Program & Expenditure Plan	2023-2026 (will be included)

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X	MHSA Annual Update	2024-2027 (will be included)
X	Stand-alone INN Project Plan	See Local Review Process above

3. DESCRIPTION OF THE LOCAL NEED(S) (*Include specifics from your local MHSA community program planning process (CPPP), e.g., comments about your current EHR system, suggestions from stakeholders, e.g. County staff, contracted providers, system partners, clients, family members and other interested parties. Include challenges meeting current and future reporting requirements and business needs, past efforts to address local needs, etc.*)

Sonoma County Behavioral Health currently utilizes 3 primary systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal). The FY 21-22 contract amounts for these systems totals of $857,701, $91,970, and $34,500, respectively.

Sonoma County, like many California Counties, has struggled with implementing Federal and State requirements with our current EHR vendors and systems. The Division has minimal resources to administer our systems, and lack technical expertise in the areas of modification, enhancement, implementation and maintenance of our EHR systems.

The Division's efforts over the years to implement Avatar has been challenging and expensive, and there have been significant delays with project timelines and deliverables. SWITS provides a basic system that has been used for over a decade. As we move towards implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS), SWITS will require significant and expensive upgrades, changes to configuration, and enhancements in order to comply with the various regulatory requirements associated with DMC-ODS.

The Division has been unsuccessful with implementing the use of Avatar with our community-based organizations, which provide approximately 40% of our mental health services. As a result, we have continued to use the CANS/ANSA Data Collection and Reporting (DCAR) System in order to track and submit required CANS/ANSA outcomes data.

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The primary barriers to implementing AVATAR with county contractors comprise three domains: IT infrastructure, IT support, and cost. While some of our partnering CBOs utilize electronic health record systems already, many do not have sufficiently advanced computing and network capabilities to connect to a hosted system in a secure way, and instead remain on hybrid or paper-based systems. It is cost-prohibitive for them to purchase their own licenses/instances of AVATAR, and the county lacked sufficient funding resources to assist. Lastly, many CBOs do not have sufficient IT resources to support the ongoing testing and maintenance of an EHR system, and the county does not have sufficient internal resources to support the significantly increased volume of users resulting from CBO participation in the county's EHR. Our current EHRs are not configured for full-system use, leaving us to manage via external spreadsheets, workarounds, and add-on databases.

On 5/24/22, the Quality Assessment Performance Improvement (QAPI) section facilitated a CBO CalAIM stakeholder meeting to provide an overview of anticipated system changes, and conduct 3 listening sessions (Adult MH Providers, Youth MH Providers, Substance Use Disorder service providers). CBO attendees included Program Directors, Clinical Directors, Quality Management Teams, and Billing/Claiming Teams. Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.

Additionally Sonoma County, like many California Counties, has struggled with hiring and retaining staff. Currently 26% of the behavioral health positions are vacant. One of the reasons that staff state as a contributing factor for terminating employment with the county is the cumbersome and time-consuming electronic health record, Avatar. Having an electronic health record that is more user friendly and less time consuming will ease the administrative burden on staff and we expect that this will help with both retaining and hiring staff.

4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY (*Include information describing what your County hopes to achieve by participating in the INN project, referencing the learning goals included at the end of the "Project Brief" document.)*

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Response to local need: Sonoma County Department of Health Services, Behavioral Health Division plans to participate in the Semi-Statewide Enterprise Health Record Project.

Sonoma County Behavioral Health Division is proposing to use MHSA Innovation (INN) funds to contract and participate with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements.

Sonoma County Behavioral Health Division has prioritized this project over other identified challenges because implementing a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements will address many of the barriers discussed in this proposal by providing the following:

- User friendly EHR system that reduces staff time spent on data input, and can assist with retaining staff
- CBO direct entry and interface with the county EHR
- Consolidation of the three current EHR platforms into one centralized system
- Compliance with CalAIM requirements on payment reform, policy changes, and data exchange
- Client Portal interface capability, which will increase client access and transparency

5. **DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS** (*Describe the County's CPPP for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic, and racial diversity of the County's community. Include details of stakeholder meetings, i.e. number and demographics of participants, community groups and system partners, methods of dissemination of information about the proposed project and comments received regarding the INN project.)*

Since April of 2022 the County has been discussing the project with a variety of stakeholders including; MHSA Community Program Planning (CPP) Workgroup, MHSA Steering Committee, Mental Health Board, Department of Health Services leadership, Division Management Team, Division CBO contractors and Board of Supervisors.

Date	Committee	Feedback

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4/7/22	MHSA Community Program Planning (CPP) Workgroup	One CPP Workgroup member stated that she supported the plan since it was being designed to help retain staff and allow staff to focus on clients and spend less time on entering data.
5/11/2022	MHSA Steering Committee	One member stated that she was an intern at the county and Avatar, the county's current EHR, was very difficult and time consuming to use. She was very exited about the project.
5/22/22	CBO CalAIM Stakeholder Meeting	Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.
5/26/22	Department of Health Services Leadership	Department Director, Tina Rivera, reviewed the proposal, including the budget and the risks and benefits associated with the project. After reviewing all of the data the Department Director approved moving forward with the project.
6/20/2022	Posted on Behavioral Health Division Website and notified	No comments were received about the posting.

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	over 2000 MHSA stakeholders via the MHSA listserv	The Steering Committee, CPP Workgroup and MHB were provided with the proposal to review.
6/22/2022	Quality Improvement Committee	Announcement of upcoming changes through CalAIM and inclusion of additional members of QIC
7/19/2022	Mental Health Board Public Hearing	One member was very interested in the client portal capacity that the new EHR is planned to have. This member stated how important a client portal is to transparency.
7/26/22	Quality Assessment and Performance Improvement Section Meeting	Announced plans to collaborate with CalMHSA and other counties to implement new semi State-wide EHR. Received requests for further details about system and support for implementing new, improved system.
7/27/22	Quality Improvement Committee	Focused discussion of CalAIM and EHR Project. Participants identified the importance of meaningful participation from peers and family members in the project.
8/10/2022	MHSA Steering Committee	One member had questions about the use of CFTN funds and how the county was funding Avatar. Avatar and the County staff are currently both being funded by CFTN.
9/13/2022	Sonoma County Board of Supervisors Meeting	Agenda item detailing EHR plan and receiving approval to enter into Participation agreement with CalMHSA for development and implementation.

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6. CONTRACTING *(What project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?)*

The QAPI Section Manager is leading the EHR project, as the senior manager responsible for CalAIM implementation. The current AVATAR Clinical Implementation Lead is providing back-up support, and the MHSA Coordinator is providing additional support. The current Implementation Team and supporting subject matter experts are as follows:

Name	Position	Project Role
Chris Marlow	QAPI Section Manager (MH and SUD)	Lead Coordinator
Wendy Wheelwright	Adult Services Section Manager	Clinical Implementation Lead for legacy system
Waheed Bhatti	Systems Service Analyst	IT Implementation Lead for legacy system
Heather Meyers	Revenue and Claiming Manager	Billing/Claiming Implementation Lead for legacy system
To Be Assigned	EHR Clinical Lead Resource	Dedicated support for clinical system implementation and maintenance
To Be Assigned	EHR IT Lead Resource	Dedicated support for IT system implementation and maintenance
To Be Assigned	EHR Billing/Claiming Lead Resource	Dedicated support for Billing/Claiming system implementation and maintenance
Melissa Ladrech	MHSA Coordinator	MHSA Innovation project liaison
Lisa Nosal	Documentation and UR Manager	Content expert – documentation
Katrina Suprise	Quality Assurance MH	Content expert – forms development, policy, and procedures
Nathan Hobbs	Quality Improvement MH	Content expert – system workflows, provider network, data reporting
Will Gayowski	Quality Assurance SUD	Content expert – DMC-ODS
Jennifer Pimentel	Compliance	Content expert – billing/claiming, compliance review

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Ken Tasseff	Privacy and Security Officer	Content expert – patient privacy, record sharing, system interoperability
Roy Dajalos	Assistant Director of Department	Fiscal oversight, executive authority
Kelley Ritter	Deputy Chief Financial Officer	Content expert – fiscal
Michele Bowman	Administrative Services Officer	Contract oversight and authority

7. COMMUNICATION AND DISSEMINATION PLAN (*Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. 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 the communication efforts?*

The MHSA Coordinator will be primarily responsible for communicating the progress, results, and lessons learned to community stakeholders, including the County Mental Health Board, Board of Supervisors, MHSA Steering Committee, CBHDA meetings, Quality Improvement Committee, and other community leaders/stakeholders. The MHSA Coordinator will leverage the MHSA Newsletter and MHSA listserv (with over 2,000 contacts) to inform stakeholders about the results, newly demonstrated successful practices, and lessons learned from the project.

8. COUNTY BUDGET NARRATIVE (*Include description of expenses for local Personnel, Operating and Consultant Costs, as well as the source(s) of funds to be used to support this multi-County collaborative. Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant,*

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part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project, and the dissemination of the Innovative project results.

Expenditure Category	Expenditure Item	Description/Explanation of Expenditure Item	Total Project Cost
Consultant	Consultant Services	In collaboration with other California counties, contract with CalMHSA for development, implementation, and maintenance of the new Semi-Statewide EHR system in our county.	Total $4,420,407.54 Per year - 22-23 $1,789.644.60 23-24 $ 703,111.14 24-25 $ 642,051.98 25-26 $ 642,545.66 26-27 $ 643,054.16

9. BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (*Please complete the Excel file for this portion of the Appendix)*

Attached

10. TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR
(*Please complete the Excel file for this portion of the Appendix).*

Attached

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: **Sonoma**

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						
7	**Total Operating Costs**						$
	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	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
11	Direct Costs	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54
12	Indirect Costs						
13	**Total Consultant Costs**						$ 4,420,447.54
	OTHER EXPENDITURES (explain in budget narrative)	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
14							
15							
16	Total Other Expenditures						$

EXPENDITURE TOTALS	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
Personnel (total of line 1)						
Direct Costs (add lines 2, 5, and 11 from above)						
Indirect Costs (add lines 3, 6, and 12 from above)						
Non-recurring costs (total of line 10)						
Other Expenditures (total of line 16)						
TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET						

CONTRIBUTION TOTALS**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**FY 26-27**	**TOTAL**
County Committed Funds						
Additional Contingency Funding for County-Specific Project Costs						
TOTAL COUNTY FUNDING CONTRIBUTION						$ 4,420,447.54

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

COUNTY: **Sonoma**

ADMINISTRATION:

A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds						
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Administration						

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation (INN) MHSA Funds						
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding						
6	Total Proposed Evaluation						

TOTALS:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Innovation(INN) MHSA Funds*	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54
2	Federal Financial Participation						
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	Other funding**						
6	Total Proposed Expenditures	$ 1,789,664.60	$ 703,131.14	$ 642,051.98	$ 642,545.66	$ 643,054.16	$ 4,420,447.54

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.
** If "other funding" is included, please explain within budget narrative.

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EHR Multi-County Innovation (INN) Project
(DRAFT for 30 Day Public Comment)
Appendix and Budget Template – Guidelines

APPENDIX: TULARE COUNTY

1. **COUNTY CONTACT INFORMATION** (*who is your Project Lead, as provided to CalMHSA*)**:**

   - **Primary Project Lead- Michele Cruz, MHSA Manager – mcruz2@tularecounty.ca.gov**
   - **Secondary Project Lead– Angela Sahagun, Electronic Health Records Manager – asahagun@tularecounty.ca.gov**

2. **KEY DATES:** (*Include actual dates and/or expected dates, as per your local timeline)*

Local Review Process	Dates
30-day Public Comment Period (begin and end dates)	3/8/2022 – 4/8/2022
Public Hearing by Local Mental Health Board	4/5/2022
County Board of Supervisors' Approval	6/14/2022

This INN Proposal is included in: (*Check all that apply*)

	Title of Document	Fiscal Year(s)
	MHSA 3-Year Program & Expenditure Plan	
X	MHSA Annual Update	22/23
X	Stand-alone INN Project Plan	22/23

3. DESCRIPTION OF THE LOCAL NEED(S) (*Include specifics from your local MHSA community program planning process (CPPP), e.g., comments about your current EHR system, suggestions from stakeholders, e.g. County staff, contracted providers, system partners,*

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clients, family members and other interested parties. Include challenges meeting current and future reporting requirements and business needs, past efforts to address local needs, etc.)

- Tulare County MH/MHSA hosted three community stakeholder meetings to present the INN Project and receive feedback.
    - Porterville Wellness Center, Consumer/Family Member Stakeholders (Zoom) – March 14, 2022 – 1pm
    - Visalia Wellness Center, Consumer/Family Member Stakeholders (Zoom) – March 14, 2022 – 2:30pm
    - Tulare County Mental Health Board Meeting (Zoom)– April 5, 2022 – 3pm

  Tulare County Mental Health Branch faces an increasingly complex task in the upcoming years to 1) successfully integrate the California Advancing and Improving Medi-Cal state initiatives; 2) successfully integrate the Substance Use Disorder treatment and services provided within the Branch; 3) grow and retain a robust and dynamic workforce in a Health Provider Shortage Area; and 4) modernize an integrated health record system that can efficiently and effectively provide data for decision making, not just for care provision for the consumers served but also for administration as the Branch looks to performance outcomes and measures to successfully implement payment reform.

  In addition to those demands on Tulare County Mental Health, the civilian labor force peaks at 9.6% unemployment rate, which is significantly higher than the State's average of 4.1%. Tulare County is also a Health Provider Shortage Area (HPSA) which means it is harder to attract and retain a health provider workforce. With this Project, the Branch hopes to improve the work experience, reducing the challenges and barriers in providing services, and retain and grow a robust and dynamic workforce.

  The current electronic health records system, Avatar, is an antiquated system that requires cumbersome documentation from clinical users which can lead to significant burnout and attrition. Additionally, poorly designed system configurations create barriers for accessing data and timely decision making. Finally, the current system is not designed to support interoperability, critical data exchange opportunities, and Substance User Disorder treatment integration that would lead to improved health outcomes for consumers. With CalMHSA's assistance in this Human Centered Design approach, and working with our providers as subject matter experts in their daily clinical operations, Tulare County MH anticipates the new enterprise health records system will be responsive to the needs of the workforce as well as the consumers they serve.

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There are two goals locally. In Phase One, Tulare County Mental Health would like to focus on growing and retaining our local workforce, providing a tool with this Project, that is user-friendly, efficient and effective in communicating between providers and teams in order to be able to provide the best possible care for consumers. Tulare County Mental Health is hopeful that employee retention will improve as this Project provides opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

In May 2021, the Branch brought in a consulting firm to survey employees in an effort to gauge employee satisfaction. Overall, 66% of employees surveyed were somewhat-engaged or not engaged. The Administration group had the largest percentage of those not engaged (32%), while the Case Management group had the largest percentage of those only somewhat-engaged (70%). Additionally, when asked about whether employees were considering leaving their current position within the next year, 29% responded yes, and 14% preferred not to say. Drilling down on those responses showed that majority of those considering leaving were not engaged or somewhat-engaged. While there are many varied factors that were assessed in this employee engagement survey, Tulare County Mental Health looks to this Innovation Project as a step to improving employee satisfaction and retention.

A second goal is to continue integrating SUD services with mental health services for providing care that addresses all the needs of an individual, in tandem with CalAIM changes. Tulare County Mental Health is hopeful that this Project will provide opportunities for eliminating redundancy, improved communication, improved documentation to reduce staff burden, and improved data collection and reporting.

The Branch looks to provide a business solution to the challenges facing behavioral health plans across the state that supports the breadth and scope of the needs of provider staff, administrative leaders, and ultimately the consumers; improving the quality of mental health programs and services by allowing providers the ability to receive data and other information in a timely manner to make decisions for administering appropriate care, and advancing a Whole Person Care delivery system model to include Substance Use Disorder treatment and services seamlessly. With CalMHSA assistance through this Innovation project, Tulare County MH anticipates improvement in workforce satisfaction and retention. Tulare County Mental Health would like to effect local level system change with the goal of improving the quality of behavioral health services while maintaining workforce development, satisfaction, and retention.

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4. DESCRIPTION OF THE RESPONSE TO LOCAL NEED(S) AND REASON(S) WHY YOUR COUNTY HAS PRIORITIZED THIS PROJECT OVER OTHER CHALLENGES IDENTIFIED IN YOUR COUNTY (*Include information describing what your County hopes to achieve by participating in the INN project, referencing the learning goals included at the end of the "Project Brief" document.)*

- As with many counties across California, Tulare County Mental Health and Community Partners are uniquely situated to participate in this Multi-County INN project. Stakeholders across our system have expressed deep concern on the volatile and antiquated EHR system that is currently utilized. Stakeholders have prioritized this project to improve and enhance the EHR system to meet the needs of the provider and consumer community alike. With this unique multi-county collaborative, Tulare County will gain an opportunity to provide continuous feedback through system end-users, providers, contractors, consumer/family member staff and recipients of care. This broad stakeholder group will serve as an essential feedback loop to program design, system design and evaluation alike. Tulare County Mental Health hopes to achieve the following learning goals in participation with this INN Project:
    - Using a Human Centered Design approach, identify design elements of a new Enterprise Health Records to improve our local behavioral health workforce's job effectiveness, satisfaction, and retention
    - Implement a new EHR this is more efficient to use, resulting in a 30% reduction in time spent documenting services, thereby increasing the time spent providing direct care
    - Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client.

5. DESCRIPTION OF THE LOCAL COMMUNITY PLANNING PROCESS (*Describe the County's CPPP for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic, and racial diversity of the County's community. Include details of stakeholder meetings, i.e. number and demographics of participants, community groups and system partners, methods of dissemination of information about the proposed project and comments received regarding the INN project.)*

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This Innovation Project plan was presented to MHSA stakeholders during the Community Planning Process (CPP) for the Annual Update Plan for Fiscal Year 2022/2023. The project was discussed at stakeholder meetings at the wellness centers on March 14, 2022.

Stakeholders at these meetings included consumers, family members, and providers. Total stakeholders in attendance were 20. No specific comments on the Innovation project were made during those meetings. Prior to this stakeholder meeting, the wellness center staff advertised the meetings on their calendar of events along with flyers. MHSA staff also shared information about the meetings through external website, social media postings, and with committees.

Tulare County Behavioral Health staff also discussed the project at the Adults and Children's System Improvement Committees as well as the Quality Improvement Committee, at earlier meetings (prior to March and April) and questions were asked about time frames, implementation, vendor selection. All questions were answered during those meetings. These meetings include providers, agency partners, and peers. Attendance varies between 15-30 attendees, and includes partners from outlying, underserved areas within Tulare County.

The Annual Update Plan was circulated for 30 days for review and comment, via the County Health & Human Services Agency external website; notices posted in local newspapers; electronic copies emailed to stakeholders; with hard copies distributed upon request. The 30-day stakeholder review and public comment period took place from March 8, 2022 to April 8, 2022. A public hearing was then held during the Mental Health Board meeting on April 5, 2022. Discussion was held during the April 5 Mental Health Board meeting on this action item. Three public comments were received during the 30-day public comment period; none addressed the Innovation Project specifically. No public comments were received during the public hearing held at the April 5 Mental Health Board meeting, and the Mental Health Board reached a quorum and voted to move the Annual Update Plan forward to the Board of Supervisors. The Tulare County MHSA Annual Update Plan for Fiscal Year 2022/2023 was approved by the Board of Supervisors on June 14, 2022.

The Innovation project was separately highlighted during the April 5 Mental Health Board meeting, and all board members approved it for submission to the Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

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6. CONTRACTING *(What project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?)*

- **Organizational Management:**
  - MHSA Manager will serve as Lead Contact for the EHR INN Project.
    - Experienced in stakeholder engagement and chairs the following stakeholder system committees such as: MHSA Providers, Wellness & Recovery Committee.
    - Manages the MHSA 3 Year Plan and Annual Update Community Planning Process annually and additional stakeholder engagement projects as needed.
  - Electronic Health Records Manager will serve as Alternate Contact for the INN Project.
    - Oversees EHR programs and implementation of new programs, processes, etc., within the electronic health record system.
  - An Electronic Health Records Specialist Supervisor and an Administrative Specialists will serve as project management and fiscal oversight.
    - EHR Specialist Supervisor oversees program design and data collection methods implementation.
    - Administrative Specialists are experienced in project management, state reporting requirements both programmatic and fiscal, and development of policies, procedures, etc., within the Agency.
  - Electronic Health Records Specialists (3) will be utilized for program design, data collection methods, trainings.

- **Contract Monitoring:**

  The MH Administration Team will provide updates on the Project at the Quality Improvement Committee, the Adult and Children's System Improvement Committees, as well as the MHSA Provider meetings. These meetings are attended by community-based partners who are part of the Mental Health Plan as well as consumers and family members. Tulare County Mental Health also has an established Mental Health Cultural Competency Committee which meets regularly and is made up of peer specialists, community organizations, clinicians and county staff. This committee will be informed on a regular basis as to the status and outcomes of the project.

  Evaluation of the project will also be shared with the Mental Health Board, with recommendations from the committees mentioned above regarding the project success

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and continuation, to be shared with the Mental Health Board for their advice and action.

7. COMMUNICATION AND DISSEMINATION PLAN (*Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. 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 the communication efforts?*

- Annual reports on the project will be shared with the Mental Health Board, and publicly available on the Tulare County HHSA website. Program participants, family members, and stakeholders will be encouraged to participate in stakeholder meetings. Shared experiences on the project's impact in the lives of our community will be welcomed. Additionally, Tulare County Mental Health will share findings statewide with county counterparts through making the project evaluation available online as well as through email listings and state MHSA associations.

- Tulare County Mental Health will work with CalMHSA and its program partners to disseminate information regarding the EHR Multi-County Innovation Project to local stakeholders and counties.

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

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Tulare County Phase 1 was submitted separately for planning purposes and was approved by the MHSOAC on June 20, 2022, for $1 million.

Phase 2 will cover the implementation of the Semi-Statewide EHR Innovation project.

Tulare County anticipates continued investment of $1.3 million in this project after the INN 5-year project period through CFTN funding in years 6 and 7.

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Tulare County Phase 2 Budget Narrative

PERSONNEL

Classifications:

MHSA Manager: $26,699
0.1 FTE will provide oversight and manage the stakeholder engagement and collaboration within our county.

Electronic Health Records (EHR) Manager $52,439
0.1 FTE will provide oversight in the implementation of the new Semi-Statewide EHR system in our county.

EHR Specialist Supervisor $113,075
0.25 FTE will provide support of the new Semi-Statewide EHR system in our county.

EHR Specialist $1,171,906
3.0 FTEs will provide support of the new Semi-Statewide EHR system in our county.

Administrative Specialist $93,569
0.2 FTE will provide administrative and fiscal support to the new Semi-Statewide EHR system in our county.

Payroll Taxes and Benefits: $559,534
Costs are identified by forecasting of actual benefit costs and assumes continued employment of existing staff.

TOTAL PERSONNEL EXPENSES **$2,017,221**

OPERATING EXPENSES

Direct Costs:
Communication: $35,500
Includes phones, cell phones, data lines, etc.
Office Expenses: $77,500
Includes general office supplies and
expenses. Training: $5,000
Includes any trainings associated with the Semi-Statewide EHR system.
Travel/Transportation: $15,000
Includes any travel associated with the Semi-Statewide EHR system.

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TOTAL DIRECT OPERATING EXPENSES	$133,000
INDIRECT OPERATING EXPENSES	$280,000
TOTAL OPERATING EXPENSES	**$413,000**
CONSULTATION/CONTRACT EXPENSES	**$3,850,800**
TOTAL PHASE 2 BUDGET	**$6,281,021**

9. BUDGET & FUNDING CONTRIBUTION BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (*Please complete the Excel file for this portion of the Appendix)*

- *Attached as requested*

10. TOTAL BUDGET CONTEXT: EXPENDITURES BY FUNDING SOURCE & FISCAL YEAR (*Please complete the Excel file for this portion of the Appendix).*

- *Attached as requested*

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

COUNTY: *TULARE*

EXPENDITURES

	PERSONNEL COSTS (salaries, wages, benefits)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1	Salaries	$ 163,495	$ 309,834	$ 319,783	$ 328,998	$ 335,577	**$ 1,457,687**
2	Direct Costs						**$ -**
3	Indirect Costs	$ 62,861	$ 118,972	$ 122,729	$ 126,224	$ 128,748	**$ 559,534**
4	**Total Personnel Costs**	**$ 226,356**	**$ 428,806**	**$ 442,512**	**$ 455,222**	**$ 464,325**	**$ 2,017,221**

	OPERATING COSTS*	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
5	Direct Costs	$ 26,600	$ 26,600	$ 26,600	$ 26,600	$ 26,600	**$ 133,000**
6	Indirect Costs	$ 80,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	**$ 280,000**
7	**Total Operating Costs**	**$ 106,600**	**$ 76,600**	**$ 76,600**	**$ 76,600**	**$ 76,600**	**$ 413,000**

	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	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
11	Direct Costs	$ 876,474	$ 788,899	$ 727,907	$ 728,470	$ 729,050	**$ 3,850,800**
12	Indirect Costs						**$ -**
13	**Total Consultant Costs**	**$ 876,474**	**$ 788,899**	**$ 727,907**	**$ 728,470**	**$ 729,050**	**$ 3,850,800**

	OTHER EXPENDITURES (explain in budget narrative)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
14							**$ -**
15							**$ -**
16	Total Other Expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

EXPENDITURE TOTALS	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
Personnel (total of line 1)	$ 163,495	$ 309,834	$ 319,783	$ 328,998	$ 335,577	**$ 1,457,687**
Direct Costs (add lines 2, 5, and 11 from above)	$ 903,074	$ 815,499	$ 754,507	$ 755,070	$ 755,650	**$ 3,983,800**
Indirect Costs (add lines 3, 6, and 12 from above)	$ 142,861	$ 168,972	$ 172,729	$ 176,224	$ 178,748	**$ 839,534**
Non-recurring costs (total of line 10)	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Expenditures (total of line 16)	$ -	$ -	$ -	$ -	$ -	**$ -**
TOTAL INDIVIDUAL COUNTY INNOVATION BUDGET	**$ 1,209,430**	**$ 1,294,305**	**$ 1,247,019**	**$ 1,260,292**	**$ 1,269,975**	**$ 6,281,021**

CONTRIBUTION TOTALS**	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
County Committed Funds	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021
Additional Contingency Funding for County-Specific Project Costs						
TOTAL COUNTY FUNDING CONTRIBUTION	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

COUNTY: ***TULARE***

ADMINISTRATION:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:						
1	Innovation (INN) MHSA Funds	$ 959,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,031,021
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding						$ -
6	Total Proposed Administration	$ 959,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,031,021

EVALUATION:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:						
1	Innovation (INN) MHSA Funds	$ 250,000	$ -	$ -	$ -	$ -	$ 250,000
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding						$ -
6	Total Proposed Evaluation	$ 250,000	$ -	$ -	$ -	$ -	$ 250,000

TOTALS:

		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:						
1	Innovation(INN) MHSA Funds*	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding**						$ -
6	Total Proposed Expenditures	$ 1,209,430	$ 1,294,305	$ 1,247,019	$ 1,260,292	$ 1,269,975	$ 6,281,021

* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting approval to spend.
** If "other funding" is included, please explain within budget narrative.

Ventura County Behavioral Health

Board Letter Summary of Contracts for September 2022

Board Date	Contractor	Amount	Term	Description
9/13/2022	California Health and Human Services Agency	$0	Effective January 31, 2023	**Data Sharing Agreement with the California Health and Human Services Agency.** The California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Quality Improvement Program (BHQIP) is a California Department of Health Care Services (DHCS) incentive payment program to support Mental Health Plans (MHP), Managed Care Plans (MCP), Drug Medi-Cal State Plans (DMC), and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) to prepare for changes to the delivery and payment of mental health and related services as part of the implementation of the CalAIM initiative and other Newsom Administration priorities. Under the CalAIM BHQIP, VCBH is eligible for a portion of the incentive payments provided that VCBH achieves certain milestones related to its ability to exchange client and patient data for the implementation of CalAIM. In order to receive 100% of the available CalAIM BHQIP incentive funds, VCBH must demonstrate that it has begun to improve its data exchange capabilities by September 30, 2022, specifically by preparing and executing a data sharing agreement that commits VCBH to sharing certain records and information through an electronic health record system that meets certain operability standards. In recent communication with DHCS regarding how to fulfill the requirements of this milestone, DHCS informed VCBH that it must specifically sign the Data Exchange Framework DSA established by CalHHS. The Data Exchange Framework DSA was developed by CalHHS, DHCS, and other stakeholders in response to state legislation requiring, among other things, improved data exchange between MHPs, MCPs, DMCs, and DMC-ODSs. The DSA is intended to facilitate data exchange between the participants in compliance with applicable federal, state, and local health privacy laws and regulations, including but not limited to Health Insurance Portability and Accountability Act of 1996 (HIPAA), federal law governing the confidentiality of substance use disorder records, and Welfare and Institutions Code section 5328. The goal is to prepare a single data sharing agreement that establishes a common set of policies and procedures that governs the exchange of health information among California MHPs, MCPs, DMCs, and DMC-ODSs for the implementation of CalAIM. There is no fiscal impact for this Agreement.
9/20/2022	DHCS	$0	July 1, 2022 through June 30, 2027	**Standard Agreement with DHCS for the Provision of Specialty Mental Health Services to Medi-Cal Beneficiaries.** VCBH is designated as Ventura County's local mental health plan (MHP) administrator by DHCS and is responsible for providing or arranging for the provision of specialty mental health services to Medi-Cal beneficiaries in Ventura County. The Standard Agreement with DHCS specifies the federal and state requirements that VCBH must meet to participate as a MHP and be reimbursed for all medically necessary covered services provided to Medi-Cal beneficiaries. The Standard Agreement includes terms and conditions related to: (1) scope of services, (2) financial requirements, (3) management information systems, (4) quality improvement system, (5) utilization management program, (6) access and availability of resources, (7) provider network, (8) documentation requirements, (9) coordination of continuity of care, (10) information requirements, (11) beneficiary problem resolution, (12) program integrity, (13) reporting requirements, (14) peer support services, (15) budget and payment provisions, and (16) other general terms and conditions related to the services. New terms and conditions incorporated into the Standard Agreement include: (1) criteria for beneficiaries to access specialty mental health services, (2) provisions and guidelines for the delivery of Medi-Cal peer support services, (3) MEDSLITE Access account and data management requirements, and (4) additional electronic and IT accessibility non-discrimination requirements. There is no change to the amount of the Standard Agreement; it remains at zero dollars. DHCS determined that this amount made the most sense because the funding that is used to pay for specialty mental health services flows through different payment mechanisms (realignment distributions and estimated total cost of the Federal Financial Participation); the Standard Agreement is not the method by which those funds are paid to counties. In addition, the zero dollar amount eliminates the need for future amendments to change funding amounts based on actual or estimated expenditures. There is no fiscal impact for this Agreement.
9/20/2022	Dennis M. Giroux & Associates, Inc. (DMG)	$466,924	July 1, 2022 through January 31, 2023	**Eighth Amendment to the Agreement with DMG for the Provision of DMC-ODS Substance Use Disorder (SUD) Services.** DMG provides outpatient DMC-ODS SUD treatment services to adults involved in the criminal justice system at various locations in Ventura County, including Oxnard, Ventura, and the Todd Road County Jail as well as in the Juvenile Justice Facility. DMG is also completing contingency management pilot program start up services for VCBH for Medi-Cal beneficiaries with stimulant use disorder. DMG uses the following evidence-based practices: matrix, seeking safety, and moral reconation therapy. In April 2022, VCBH conducted a site review audit of DMG to review their FY 2021-22 program, utilization review, fiscal, staffing, and physical plant operations. The site review process, designed to ensure that DMG is in compliance with the requirements specified in the contract and all applicable Federal, State, and local regulations, resulted DMG being issued a Corrective Action Plan (CAP) that identified various issues that require remediation. Because of these issues, VCBH limited its FY 2022-23 extension of its contract with DMG to a three-month term, specifically July 1, 2022 through September 30, 2022, pending review and finalization of the site review audit CAP. VCBH requires additional time to complete its review and finalize the DMG site review audit CAP process. The Eighth Amendment extends the agreement with DMG at existing terms for an additional four months ending January 31, 2023 and increases the maximum agreement amount accordingly to allow VCBH to complete its review and audit process. This agreement is funded by Drug Medi-Cal Federal Financial Participation (D/MC FFP), Realignment, AB 109 funds and DHCS BHQIP funds.