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Orange County Mental Health Services Act (MHSA) Performance Audit

Review of Finances, Decision Making & Contracting

Summitted to Orange County Board of Supervisors
by California Health Policy Strategies, L.L.C.
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Executive Summary

In response to concerns about Orange County's Mental Health Service Act (MHSA) program, the Orange County Board of Supervisors engaged California Health Policy Strategies, LLC (CalHPS) to undertake an analysis of current processes and to make recommendations for improvements. The CalHPS's team conducted approximately 50 interviews over the past six months to gather data. Additionally, data from the county and state was analyzed to inform recommendations.

Public concern revolves around a consistent question: How much money is available to spend? At the most fundamental level, policy-makers, stakeholders, and the public must know this answer in order to inform decisions. Perceived large unspent funds, high Prudent Reserves, and a lack of information in Orange County's MHSA budget reporting are the chief complaints heard in interviews. Another area of concern raised was how MHSA priorities are established and expenditure decisions are made, as well as the timeline and processes used to make such decisions. Lastly, how the county interacts with vendors and how the contracting process impacts the timing of getting services into the community was identified as a concern.

The three key areas for improvements and corresponding recommendations are summarized below. The list represents a summary only. Please refer to page 39 for all recommendations.

- ✓ **Budget transparency**
  - Establish a clear, consistent and credible budget display. This display should delineate the prudent reserve, an operating reserve, and funds that are obligated but unspent and funds that may be subject to reversion if not spent by a certain date. There should also be a consistent process used for updating this display throughout the year as needed.

- ✓ **Expenditure Decision Making and Stakeholder Engagement**
  - Create a Stakeholder Committee that should be non-voting and advisory. The Committee should oversee both MHSA and Behavioral Health programs.
  - Create a mental health dashboard.

- ✓ **Implementation – Procurement process and management of contracts**
  - Establish a formal and informal engagement process with vendors
  - Develop a Master Contract for vendors that have more than one MHSA contract
  - Consider modifications to contracts based on over or under performance.

While this report addresses many of the concerns raised by stakeholders and offers recommendations for improvements, Orange County should consider spending additional time studying how other similar counties make decisions on expenditures and manage MHSA contracts to determine if there are additional opportunities to improve the county's mental health system.

Methodology

In response to concerns about Orange County's Mental Health Service Act (MHSA) program, the Orange County Board of Supervisors engaged California Health Policy Strategies, LLC (CalHPS) to undertake an analysis of current processes and to make recommendations for improvements.[1] CalHPS is a Sacramento-based consulting group with extensive experience in state government and health related programs.

To better understand the current MHSA program in Orange county, the CalHPS team conducted approximately 50 interviews with county staff, community stakeholders, vendors, and state officials in the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission (MHSOAC). In addition, discussions were held with MHSA program coordinators in four other counties. The team also reviewed available state and county MHSA expenditure data and performance measures.

As a result of these interviews and review of the data, three key areas were identified:

- ✓ Budget transparency
- ✓ Expenditure Decision Making and Stakeholder Engagement
- ✓ Implementation – Procurement process and management of contracts

This report provides an overview of the MHSA program, identifies concerns, and offers recommendations.

[1] Orange County Board of Supervisors Agenda, March 13, 2018.

Background to MHSA Program

Overview of MHSA

The Mental Health Services Act (MHSA), also known as Proposition 63, passed in November 2004 with 53.8% of the vote. The MHSA was created to address a broad continuum of mental health services including prevention, early intervention, and treatment services. In addition to providing funding for these direct service needs, it also provides funding for infrastructure, technology, innovation, and training to support the mental health services system. The funds for MHSA are generated through a "millionaire tax" which imposes a 1 percent income tax on personal income in excess of $1 million.

The revenues generated from the tax surcharge can only be used for expanding mental health services. It prohibits current funds directed to mental health services from being re-directed. Additionally, the MHSA included a maintenance of effort requirement that bars the state from reducing any levels in mental health services below the levels in the 2003-04 budget.

Historically, counties have been responsible for providing mental health services to their residents. While planning and delivery of county services is conducted on a local level, state funds account for the majority of mental health services funding. Prior to the MHSA, since 1991, the services provided by the counties were funded by a dedicated portion of state sales tax dollars and vehicle license fees as well as any funds received from Medicare and other third-party payers. In addition, counties receive federal Medicaid matching funds for half of the cost of Medi-Cal covered services when provided to Medi-Cal eligible individuals.

Statewide, when first passed, Prop 63 revenues constituted approximately 10 percent of the entire public mental health budget. Now, it comprises approximately 24 percent.[2] In FY 2017-2018, MHSA funding was more than $1.8 billion. However, recent history is an important reminder of MHSA's sensitivity to downturns in the economy and the volatile nature of its revenue. For example, MHSA revenues dropped from $1.140 billion in 2010-2011 to $849 million in 2011-2012, almost 26 percent below the previous year. But when the economy improved, revenue swung in the opposite direction. In FY 2012-13, for example, state MHSA revenues increased to $1.362 billion, more than 60 percent above the $849 million in revenue in 2011-12.[3] This up and down pattern of wide swings has repeated itself over the life of the MHSA and is likely to recur in the future as the economy ebbs and flows. This funding uncertainty has added a level of caution in committing funding to on-going projects so as to maintain reserves to prevent service cutbacks when revenues decline.

[2] Mental Health Services Oversight and Accountability Commission website
[3] Mental Health Services Act Oversight and Accountability Commission Revenue Summary Fact Sheet

MHSA funds are allocated to the 59 local mental health jurisdictions in the state through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are also made for the cost of living. Lastly, the formula also provides a minimum allocation to rural counties for two service-related parts of the program (Community Services & Support and Prevention Early Intervention components).

There are five components of the Mental Health Services Act which are described below (CCS, PEI, INN, CFTN, and WET). MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

The remainder of the funds are allocated to the counties through three separate funding streams:

- ✓ **Community Services & Support (CSS)** - 80% of the funds
  - The CSS component is focused on community collaboration including full service partnerships, cultural competence, outreach and engagement activities aimed at reaching and providing necessary services to unserved and underserved populations. Housing is also a part of the CSS component. Use of CSS funding is restricted to services and programs that serve people living with serious emotional disturbance or serious mental illness.

- ✓ **Prevention & Early Intervention (PEI)** - up to 20% of funds
  - PEI programs are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness. The goal of PEI is to help counties implement services that promote wellness, foster health, and prevent suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs.

- ✓ **Innovation (INN)** -- up to 5% of funds
  - Up to five percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness. The Mental Health Services Act Oversight Commission (MHSAOC) must approve specific innovation projects before INN funds can be spent.

The MHSA also requires counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have had the option of using a portion of their CSS funding in these areas:

- ✓ **Capital Facilities & Technological Needs (CFTN)**
  - This component finances capital and infrastructure to support implementation of MHSA programs. It also includes funding to improve or replace technology systems.

- ✓ **Workforce Education & Training (WET)**
  - This component aims to train more people to remedy the shortage of qualified individuals who provide mental health services. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

Passage of the MHSA provided a much-needed funding stream to support counties' efforts to prevent, identify, and treat mental illness. However, the unique aspects of the MHSA program present challenges to counties that complicate the planning and budgeting process for this program.

- Revenues are highly unpredictable, a consequence of taxing the income of a limited pool of high-income tax payers whose income is volatile because it often dependent on the amount of capital gains realized. This uncertainty about annual MHSA funding creates an added challenge to implementation and an added risk for planning programs and services.
- Cash flow varies significantly during the fiscal year; approximately 40 percent of cash transfers are received in the last three months of fiscal year.
- Unspent funds revert if the funds received under the MHSA are not spent within specified timeframes. For Orange County, the following timelines apply: Three years for funds dedicated to Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation programs; and ten years for capital facilities, technological needs, or education and training.
- The state's Mental Health Services Oversight and Accountability Commission (MHSOAC) must receive the county's three-year plan and proposals for Innovation projects before INN funds can be spent.

Overview of MHSA Administration

When the MHSA passed in 2004, the responsibility for overseeing the programs went to two state entities—the California Department of Mental Health and the newly-created Mental

Health Services Oversight and Accountability Commission (MHSOAC). Since the 2012 elimination of the Department of Mental Health, the California Department of Health Care Services (DHCS) has taken responsibility along with the MHSOAC for providing oversight for the MHSA program.

The two state entities with oversight responsibility for the MHSA have distinct roles and responsibilities. There have also been significant changes in these responsibilities since the implementation of the MHSA.

Mental Health Services Oversight and Accountability Commission. The MHSOAC is broadly responsible for "oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds."[4] The MHSOAC receives all county three-year plans, annual updates, and annual revenue and expenditure reports. In the past, the MHSOAC was responsible for review and approval of county plans for the Prevention & Early Intervention (PEI) and Innovation Program components of the MHSA. After the passage of AB 100 in 2011, the role of the Commission shifted from review and approval of county plans to providing training and technical assistance for county mental health planning, as needed. Additionally, the Commission is responsible for the evaluation of MHSA-funded programs throughout the state. When AB 1467 passed in June 2012, the MHSOAC's role of training and technical assistance and evaluation expanded, and approval of county innovation plans was reinstated.

Department of Health Care Services. The second group of oversight and administrative tasks was performed by the Department of Mental Health when the MHSA first passed in 2004, and then transferred to the Department of Health Care Services in 2012. This role focuses on managing the funds collected and distributed under the MHSA. The managing department has been responsible for collecting and publishing information about the overall financial status of the program. In the early years of the program, local mental health agencies had to obtain approval from the state Department of Mental Health for their program plans, however this requirement was eliminated in 2011. Currently, local agencies are required to obtain prior approval only for their proposed innovation programs from the Oversight and Accountability Commission.

The state has been criticized since virtually the inception of the MHSA for providing a lack of oversight to counties regarding several important aspects of financial management for the MHSA funds. Reports from the State Auditor and the Little Hoover Commission[5] have cited, among other things:

[4] Mental Health Service Act, W&I Section 5845(d)(6).

[5] Mental Health Services Act: The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance**,** California State Auditor, August 2013**,**

- An incomplete picture of the overall use of the MHSA funds because the large number of agencies that have not submitted the required reports.
- Lack of guidance on how to manage MHSA finances such as the handling of interest earned on unspent funds, the adequacy of a prudent reserve, and process for complying with the reversion requirements of the MHSA.

However, since 2017, there has been progress in clarifying the financial aspects of the program. In 2017, the Legislature spelled out the mechanisms by which the reversion requirements of the MHSA would be implemented. The Budget Trailer Bill (AB 114), signed by the Governor on July 10, 2017 in effect deferred the reversion of any past unspent revenue and allowed innovation funds to be retained for an extended period if committed to an approved program. The department has also clarified how interest is to be accounted for and becomes subject to reversion. DHCS has also implemented measures to incentivize counties to submit their annual financial reports on a timely basis.

There is ongoing concern about the need for the state to provide clearer guidance on how much a county should maintain in uncommitted revenue to protect against declines in revenue. The MHSA recognizes this risk and requires counties to maintain a "Prudent Reserve" in order to help pay for programs during years when revenues fall and reserved funds are needed to maintain service levels. The reserves are related to a larger conversation about local agencies leaving funding on the table by not assigning it to programs and delivering it to the community for services. Retaining larger reserve funds, beyond the Prudent Reserve, runs the risk of unspent funds reverting back to the state.

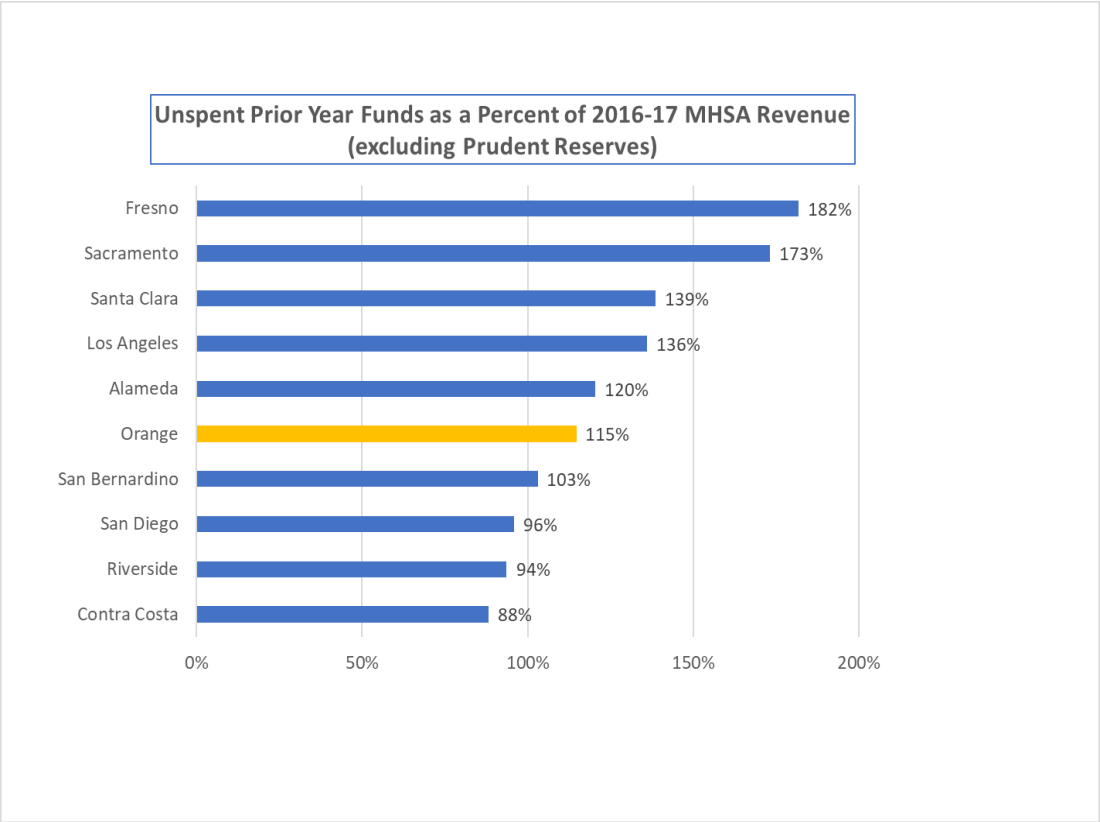
This topic has caught the attention of the media and advocates in the past year. As noted in a recent Los Angeles Times article, "as of June 2017, $1.6 billion was being held in reserve in nearly three-quarters of the counties in the state."[6]

Our analysis of the state's most recent MHSA fiscal reports indicates that Orange County has an unspent balance that is similar in size to those in other large counties. This finding is based on the FY 2016-17 county MHSA fiscal reports submitted to the DHCS and is shown in Chart 1 below.

Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding, California State Auditor, February 2018, and Promises Still to Keep: A Decade of the Mental Health Services Act, Little Hoover Commission, January 2015.

[6] With an Epidemic of Mental Illness on the Street, Counties Struggle to Spend Huge Cash Reserves, Los Angeles Times, August 19, 2018

CHART 1



In addition to the unspent funds in Chart 1 above, local agencies allocate some of their MHSA revenues to Prudent Reserves to provide funds to help maintain services if there is a decline in revenues. Up until August 2018, state guidelines did not specify an amount that local agencies could hold in their Prudent Reserves. Consultants hired to provide guidance advised some counties to set aside as much as 80 percent. Without formal guidance from the state, the size of Prudent Reserves varies greatly by county and depends on the county's leadership.

This year the state issued a policy guidance letter outlining their recommended guidance for Prudent Reserves, which were set to promulgated by July 1, 2019.[7] The letter also includes information on how they will enforce the reversion process. The state's guidance letter notes the following:

> "A county must fund its prudent reserve solely with funds allocated to the CSS component. A county shall not maintain a balance in the Prudent Reserve that exceeds **33 percent of the largest distribution to the county from the MHSF in a fiscal year**. A county with a Prudent Reserve that contains an amount larger than the 33 percent must not transfer additional funds into the prudent reserve until its

[7] DHCS MHSUDS INFORMATION NOTICE NO.: 18-033, August 1, 2018

balance is below 33 percent. DHCS will publish a notice prior to the beginning of each fiscal year informing each mental health plan of its maximum prudent reserve level."

DHCS reports that it will be releasing an information notice in September 2018 that establishes each county's maximum prudent reserve level based on the recommendations of the State Auditor Report.

SB 192, enacted this year, also addresses the issue of the Prudent Reserve and provides guidance on reversion of unspent funds. The bill was signed by the Governor September 2018. The bill:

- ✓ Establishes an MHSA Reversion Account. Requires (1) previously allocated MHSA funds that have not been spent for their authorized purpose within three years, and (2) the interest accruing on those funds to revert to the MHSA Reversion Account.

- ✓ Requires a county to calculate an amount it establishes as the prudent reserve for its Local Mental Health Services Fund. This amount may not exceed 33 percent of the average community services and support revenue received for the fund in the preceding five years. It also requires a county to reassess the maximum amount of this reserve every five years and to certify the reassessment as part of the three-year program and expenditure plan, as required in existing law.

- ✓ Requires a county which (1) has unspent funds that are deemed reverted and reallocated and (2) that has not prepared and submitted a plan to the MHSOAC as of January 1, 2019 to remit the unspent funds to the state as required in existing law, and into the Reversion Account established by this bill, no later than July 1, 2019.

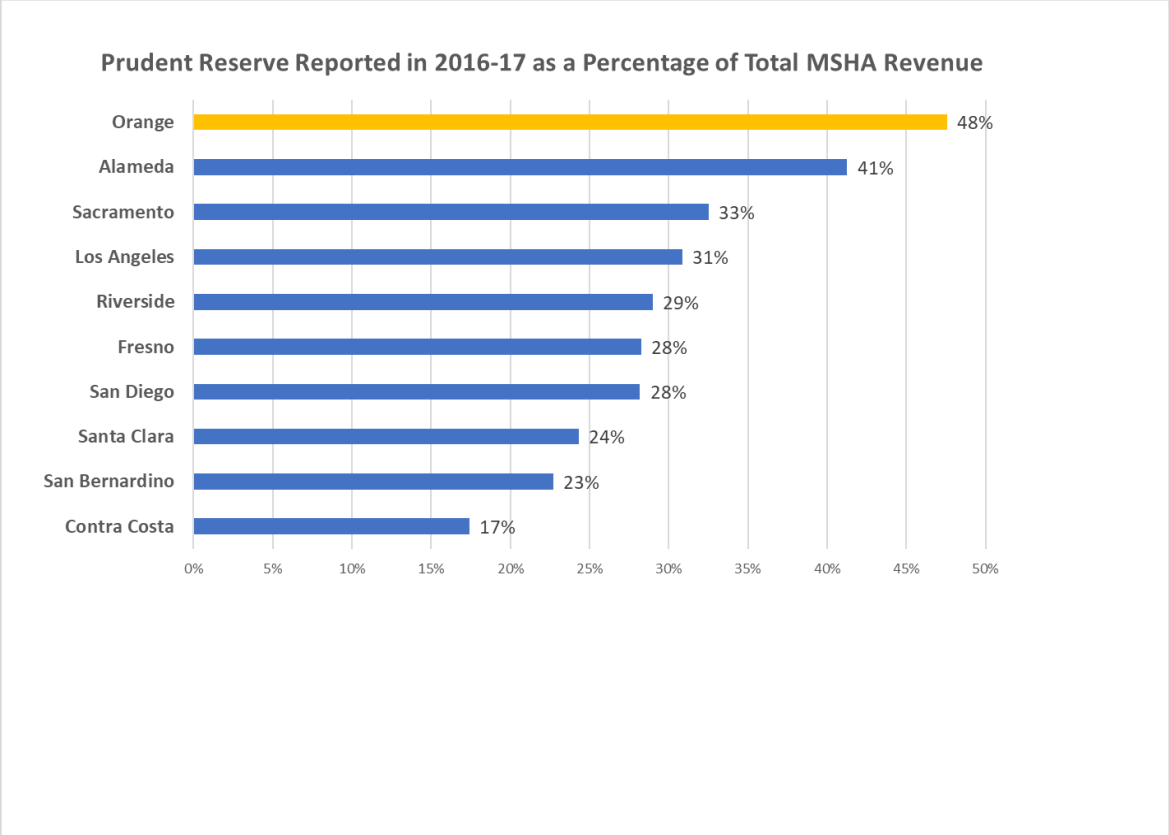
- ✓ Requires the plan for the expenditure of unspent funds deemed reverted and reallocated to be submitted to the MHSOAC for review. It also requires funds included in the plan that are not spent as of July 1, 2020 to revert to the state as required in existing law and into the Reversion Account established by this bill. Funds available in the Reversion Account are available to other counties in future years.

Using data in the financial reports available at the Department of Health Care Services, below Chart 2 shows the Prudent Reserves of the state's largest 10 counties as a percent of total MHSA revenue for FY 2016-2017. Orange County has an amount in its Prudent Reserve that is the largest among these counties. This cautious approach has resulted in a Prudent Reserve that is now beyond the level permitted under the provisions of SB 192. Using the formula set

forth in SB 192, Orange County should have a Prudent Reserve in FY 2018-19 of no more than about $33 million going forward. This is 33 percent of their estimated average annual CSS revenue received from FY 2013-14 to FY 2017-18 of $98.4 million.

At this time, it is unclear what counties will have to do to conform to the new 33 percent Prudent Reserve requirement. The county should get clarification on this issue with the state. It should be noted that in FY 2018-19, Orange County's Prudent Reserve will decrease to $59.6 million to conform with the Prudent Reserve balance DHCS has on record for Orange County. With this change, Orange County's Prudent Reserve as a percentage of total MHSA Revenue in FY 2018-19 will be 38 percent.

Chart 2



Orange County and the Mental Health Service Act

Overview of Orange County MHSA program

The Orange County FY 2018-19 MHSA Annual Plan Update ("Plan Update" or "Update") to the Three-Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 was approved by the Board of Supervisors in May 2018.

In the FY 2018-19 MHSA budget, Orange County has 63 different MHSA funded programs identified with an annual budget of $218.8 million.

- **CSS Fund**
  Community Services and Supports (CSS) is the largest of all five MHSA components and receives 76 percent of the total annual MHSA budget. The resulting CSS budget for FY 2018-19 is $145,612,490. The year for which most recent data is available (FY 2015-16) shows that 14,030 unduplicated individuals were served under CSS programing.

- **PEI Fund**
  MHSA dedicates 19 percent of its allocation to Prevention and Early Intervention (PEI), which is intended to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. This component maintained an overall annual budget of $35,452,761 for FY 2018-19, although funds were transferred from the Training, Assessment and Coordination Services program to the Violence Prevention Education, Crisis Prevention Hotline, Survivor Support Services, and Warmline programs to reflect actual program expenditures and/or increase service capacity based on demonstrated need. In addition, the MHSA Steering Committee approved the Health Care Agency's plan to spend reverted PEI funds, per Assembly Bill (AB) 114, on existing PEI programs during FY 2018-19.

  In FY 2015-16, 237,530 individuals were served. This includes 201,664 contacts (duplicated) for the county's call-in or referral services (Outreach and Engagement, OC Links, Crisis Hotline, Warmline) and 31,615 unduplicated served within program for the rest of PEI programs

- **Innovation (INN) Fund**
  MHSA designates five percent of a county's allocation to the innovation component, which specifically and exclusively dedicates funds to trying new approaches. In FY 2018-19, $12,205,299 is budgeted for INN projects. Please see the section below for more discussion and details on INN projects and spending.

- **Orange County WET Funding**
  WET maintained a level annual budget of $5,150,282 for FY 2018-19, although funds were transferred from the Financial Incentives Program and Training and Technical Assistance to Workforce Staffing Support to reflect actual program expenditures.

- **Orange County CFTN Funding**
  The Capital Facilities and Technology Needs (CFTN) component funds a wide range of projects necessary to support the service delivery system and is currently funded through CSS. A total of $9.2 million was transferred to Capital Facilities to fund two projects in FY 2018-19: $9 million to purchase a property for Co-Located Services and $200,000 for renovations to a building for MHSA programming. In addition, $8,152,825 is budgeted in FY 2018-19 for Technological Needs for continued implementation of the BHS Electronic Health Record (EHR).

Additionally, under direction from the Board of Supervisors, $35 million was allocated during the FY 2017-18 Community Planning Process to develop permanent supportive housing through the MHSA Special Needs Housing Program.

Challenges with MHSA Program in Orange County

In our discussions with policy-makers, program staff and stakeholders, several challenges relating to MHSA implementation in Orange County have been identified. These issue areas and subsequent recommendations include:

- ✓ Budget Transparency
  - Budget display – how much is available for expenditure decisions?
  - What programs are being funded?
- ✓ Expenditure Decision Making
  - Role of Stakeholders
  - Role of Data
  - Responsive Decision Making
  - Innovation Fund
- ✓ Implementation – Procurement process and management of contracts and Innovation Funding

Budget Transparency

***Issue #1**: Budget Display: How Much Is Available for Expenditures?*

MHSA numbers are complicated and so are the assumptions that go into determining the numbers that guide budget development and program spending. At the most fundamental

level, policy-makers, stakeholders, and the public are asking a simple question: How much money is available to be spent?

The State Auditor's February 2018 report found "hundreds of millions of dollars in unspent MHSA funds."[8] According to the State Auditor's analysis, the fund balance in 2015-16 of all 59 local mental health agencies was $2.5 billion, and $241.9 million in Orange County. It should be noted that Orange County's FY 2018-19 Plan Update reports the unspent balance at the beginning of 2018-19 at $171 million and the balance at the end of 2018-19 is expected to be $109 million.

Understanding the underlying reasons for these large fund balances continues to pose a challenge, not only in Orange County, but in all MHSA jurisdictions throughout the state.

Local stakeholders and policy-makers have complained of a lack of transparency and consistency in Orange County's MHSA budget reporting. In general, concerns were raised about inconsistent budget documentation, numbers that did not add up, and a lack of clarity concerning how much had been spent and how much was available to be spent.

Based on our discussions with the Health Care Agency and County Executive Office fiscal staff, the MHSA fund balance reflects total revenue available minus the commitments for designated programs during the year. However, there are three important additional components that must be identified and included in all budget displays and documents before being able to determine the amount that is actually available for future expenditures.

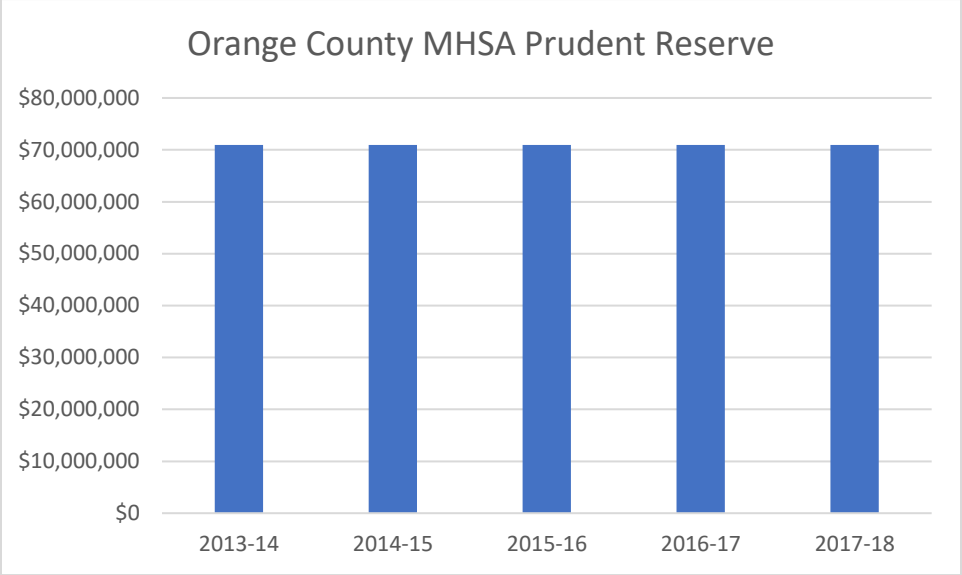
- **Prudent Reserve:** The state requires counties to have a Prudent Reserve, not subject to reversion, that is available upon state approval for when MHSA revenue declines below the historical average. This mechanism is intended to provide funds necessary in order to maintain programs during a recession. Until recently, counties had discretion to establish their own standards to manage the reserve level. According to program staff, the historical size of Orange County's Prudent Reserve had been informed by advice from an independent consultant, Geiss Consulting, who recommended a combined 80 percent of the county's MHSA allocation be put aside both for Prudent Reserve and for "On-hand" Reserves. This recommendation was based on the amount that would be required to avoid service reductions due to a recession-related decrease in MHSA revenue.

  As noted earlier, new DHCS guidance and recently enacted state legislation now require a county to maintain a Prudent Reserve that contains an amount not larger than the 33 percent of their average CSS revenue for the preceding five years.

  Chart 3 below illustrates that the county's reserve level has remained the same since FY 2013-14

[8] https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

Chart 3



- **Operating Reserve:** State rules currently impose restrictions on the ability of counties to quickly access and use funds in their Prudent Reserve. MHSOAC approval is required first. There is a concern if a modest decline in revenue occurred that was less than the state's threshold for using the reserve, program cutbacks might be necessary if all other funds were fully committed. Timing is also an issue. For example, if the county determines that it needs funds to cover monthly service expenses within two weeks, the county cannot be assured that their request to use their Prudent Reserve would be approved timely by the state to meet this need. Orange County's budget staff in both the CEO's office and at Health Care Agency have suggested a need for an "Operating Reserve," which would offer flexibility in the budgeting process to allow for short term fluctuations in the funding without going through the state's administrative process to access funds in the Prudent Reserve. We are advised that this set aside is necessary to order to cover annual operating expenses for the program that might arise and not be accounted for in the formal budget process. Not carrying an operating reserve could create a cash flow issue and there will likely be instances where the county will not receive enough funds in a given month to cover the monthly approved MHSA expenditures.

- **Unspent but Obligated:** This budget category refers to funds that have been set aside for approved programs and services and cannot be assigned for other purposes. There are two distinct ways this category can be applied.

  First, there is spending approved by the Board of Supervisors for activities or projects that require multiple years before all the funding is expended. This category could, for example, include funding earmarked for the purchase of a site for the co-location of behavioral health services. In these cases, the activities are not yet recorded as

expenditures and identified to particular programs, and the unspent revenue has in the past been shown as part of unspent carryover funds. However, these funds are not available for other uses because they are already committed.

Second, "unspent prior year funds" can also increase as the accounts for prior fiscal years are closed out, and it becomes clear that a program has not spent all the funds that were originally approved for it. These funds are available – along with other prior year unspent funds – for future spending decisions. For various reasons a program may not spend the full amount that has been obligated to it. New programs, for example, may encounter unanticipated delays in ramping up, recruiting staff, or acquiring new facilities that are necessary to fully spend their budgeted allocation in the fiscal year. In this case, these unspent funds are available for future programs and services.

Recommendations:

- **Budget Display.** Establishing a clear, consistent, and credible budget display for MHSA funds is a crucial step toward restoring confidence and transparency in the process. Specifically, we recommend the following:

    - **Prudent and Operating Reserve Levels and Rationale.** While the level of the Prudent Reserve is now set as a matter of law, the county should consider whether the funding available in the Prudent Reserve sufficiently mitigates the risk of program cutbacks during a recession. Additional funds can be held uncommitted as a further hedge against revenue falls, but not with the protection that the Prudent Reserve enjoys from possible reversion if the funds remain unspent for too long. County fiscal staff should assess whether the risks of program reductions in some future recession are sufficiently great to justify running some risk of fund reversion and recommend a policy of reserving additional funds beyond the level of the Prudent Reserve as an operating reserve to provide interim assistance before the Prudent Reserve funds can be accessed. County staff should also get clarification from the state as to what the county will have to do to conform to the new 33 percent Prudent Reserve requirement.

    - **How Much Is Available for Expenditure?** Develop a budget display that clearly allows policy-makers and stakeholders to understand how much MHSA funding is available for expenditures for the fiscal year. This display should clearly delineate the Prudent Reserve, an operating reserve, and funds that are obligated but unspent. There should also be a consistent process used for updating this display throughout the year as needed.

    - **Continue CEO Role.** Continue the process of CEO's office managing the MHSA budget and providing regular updates to the MHSA steering committee, Mental Health Board, and all other interested parties including biannual budget updates. Having dedicated staff working on this important issue will help streamline

concerns and will create a process that should lead to more timely and accurate information sharing.

In making these recommendations, we understand that changes are currently underway to provide more accurate information to stakeholders. Effective July 1, 2018, the MHSA Fund became a CEO Controlled Fund with related fiscal responsibilities being reassigned to the CEO Budget Office. As such, the CEO's office is providing quarterly updates to the MHSA Steering Committee and Mental Health Board on funding.

We also understand from discussions with other county MHSA program staff that the state had provided the original budget template that is being used by many counties. Perhaps when the program began, the information provided in the budget template was enough for decision making. However, we believe that more detailed information is necessary to accurately identify available funds as well as funds that have been obligated but not yet spent. The CEO's office, in coordination with the Health Care Agency, is working to update the budget template so that the necessary information to guide expenditure decision making on MHSA is reflected in the template. Please see Appendix 1 for the revised budget template for FY 2018-19. The CEO's office has also replicated the FY 2017-18 budget with this template.

Issue #2: What Programs Are Being Funded

Both policy-makers and stakeholders have expressed a level of uncertainty as to the number and type of programs funded by MHSA, level of funding received, number of clients served, and outcomes obtained. This information is the foundation for policy-makers to provide oversight and of the public's ability to understand expenditure decisions.

An example of this confusion relates to the number of programs funded with MHSA dollars. The Behavioral Health Division Director had previously provided an inventory of funded programs that included both MHSA funded programs and all other Behavioral Health Services programming. Additionally, the information provided listed programs by locations; consequently, one program could be listed multiple times if there was more than one location in the county. When the two issues outlined above are taken together, it appeared as though there were over 200 MHSA funded programs in the county. Upon clarification with the Health Care Agency, it is more accurate to say that there are there are 63 MHSA funded programs in FY 2018-19. Please refer to Appendix 2 for a listing of these programs provided by the Health Care Agency.

We have been working with the Health Care Agency to refine their list of programs to clarify how many MHSA funded programs there are in the county, how much funding each program is receiving, and how many people are being served.

Recommendations:

- **Standardized Template and Program Inventory**. Create a standardized template and inventory of programs that receive MHSA funds. Maintain a separate list of non-MHSA funded mental health programs in the county.

- **Four Broad Program Categories.** Categorize each of the funded MHSA programs under the following four broad areas:
    - Crisis Mental Health Services,
    - Treatment Services,
    - Prevention,
    - Support Services, and
    - Training and Infrastructure.

- **Program Descriptions.** Provide a description for each MHSA funded program that includes a brief summary of the program's revenue source and expenditure information for prior, current, and proposed fiscal years; administrative costs; locations and services; the number of people served at each location; and outcome or evaluation information if available.

Decision Making on MHSA Priorities and Expenditures

Broad concerns have been raised about how MHSA priorities are established and expenditure decisions are made. The current process includes HCA staff, the MHSA Steering Committee, public comment through the county website, public forums, and other meetings, the Mental Health Board, and the Board of Supervisors, where the final decision is made.

In general, expenditure decisions should be guided by a unifying vision of the county's policy objectives and goals for behavioral health services. This vision should be reflected in strategies that target resources where the needs are greatest, and where programs are most effective. Maximizing state and federal funding should also be part of the county's approach to getting the most out of every MHSA dollar. When new funding becomes available, the decision-making process and three-year MHSA plan should be both nimble and flexible enough to respond quickly. Finally, there must be an overarching commitment to program evaluation and outcomes based on measurable data.

Issue #1: Role of Stakeholders

Stakeholder engagement is a critical component to the MSHA and is necessary to the success of any county program. Indeed, the explicit inclusion of stakeholders in the decision process was intended by the MHSA initiative sponsors to inspire a shift in "bureaucratic, top-down" culture,

which had, some critics claimed, previously excluded participation from those most affected by the decisions. The MHSA requires that stakeholders have a "meaningful role" in the process to help provide guidance on priority setting, program direction and implementation, and governance.

The MHSA provides for some specifics on stakeholder engagement. For example, it requires that individuals representing each of the following stakeholder groups participate in this planning:

- ✓ Adults and older adults living with a mental illness
- ✓ Family members of children, adults and older adults living with a serious mental illness or emotional disturbance
- ✓ Mental health service providers
- ✓ Law enforcement agencies
- ✓ Education
- ✓ Social services agencies
- ✓ Veterans
- ✓ Representatives from Veteran organizations
- ✓ Providers of alcohol and drug services
- ✓ Health care organizations
- ✓ Other important interests

Additionally, the MHSA regulations define "stakeholders" as the following:

> "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness and or serious emotional disturbance and/or their families."[9]

The MHSA and its implementing regulations give counties the ability to design the specifics of their MHSA stakeholder process, including roles and responsibilities.

Current Role of Stakeholder in MHSA Decision Making Process in Orange County

Stakeholders play a central role in the current planning processes for determining MHSA priorities and expenditures. The focal point for these efforts is the county's MHSA Steering

[9] California Code of Regulations, 9 CCR § 3200.270. Stakeholders.

Committee. The Committee has 57 current members (and eight vacancies). Responsibilities include:

- Be fully educated about the status of MHSA funding availability and requirements, as well as the status of Orange County MHSA program implementation;
- Assist the county to identify challenges in the development and delivery of MHSA-funded services and make recommendations for strategies to address these challenges;
- Remain informed about current stakeholder meetings and the funding and program recommendations made by members of these groups;
- Review all MHSA funding proposals and provide critical feedback to ensure that funding is allocated to services for identified needs and priorities;
- Make timely, effective decisions that maximize the amount of funding secured by Orange County and preclude Orange County from losing funding for which it is potentially eligible;
- Support the County's ability to meet both state funding requirements and Orange County funding needs; and,
- Make recommendations regarding future MHSA allocations so funds will be used to provide services for identified needs and priorities.

Members of the Steering Committee are appointed by the Behavioral Health Director to provide representation of broad interests concerning the MHSA. Each organization serving on the Committee must have a designated representative and no more than one assigned alternate. According to the Department's orientation for new members, the designated representative or the alternate must be present at all meetings and attend the meeting in its entirety.[10]

Decisions are normally made via consensus (agreement of all committee members that they either support the decision or will at least not block it from going forward). A "yes" means that the decision will be actively supported or, at a minimum, nothing will be done to undermine the success of the decision.

The goal in effective consensus decision-making is to find ways to say "yes" wherever possible and to say "no" only when absolutely necessary and when a member is prepared to stop the proposed decision [as stated] from moving forward. If consensus cannot be reached, a vote will be taken of members present and a majority (51 percent) will move the decision forward.

The Steering Committee members are divided into four subcommittees that focus on funding components of the MHSA: CSS Adults and Older Adults, CSS Children and TAY, Innovation, Prevention and Early Intervention (PEI). The subcommittees process allows for more detailed information and discussion on MHSA services by a group that has a special interest in programs for a specific age group or has a special interest in programs funded by a particular MHSA component. The process also seeks to:

[10] Mental Health Services Act Orientation, June 24, 2014

- Increase stakeholder participation and involvement in decision making;
- Empower subcommittee members to make recommendations on service needs, types of programs, and measurable outcomes; and,
- Inform subcommittee members about MHSA programs and services so that they can take a leadership role in explaining to the whole Steering Committee and the community at large (1) how MHSA funds are being used and (2) the impact of MHSA programs.

Concerns about the Current Process

- **Roles and Responsibilities are Unclear:** There is uncertainty about the meaning of "decisions" by the Steering Committee. It is unclear whether the committee's primary role is to *advise* or to *decide*. Steering Committee members and other stakeholders were unclear about their own role in the formal decision-making process.

- **Procedures are not well defined**. To the extent the Steering Committee is a forum for decision making, concerns have been raised about the lack of a rigorous and formal process that allows for transparency, accountability, and availability of information. Indeed, some steering committee members expressed their discomfort about being asked to vote on issues for which they felt unprepared. Procedures are ill defined regarding rules on quorums, public notice, availability of agenda and materials in advance of the meeting, minutes, etc. Steering Committee members also expressed a level of ambiguity as to whether decisions are made on the basis of a consensus or a majority vote. Establishing formal decision-making processes and procedures requires significant staff resources, a particular challenge to provide support for a committee of over 57 members.

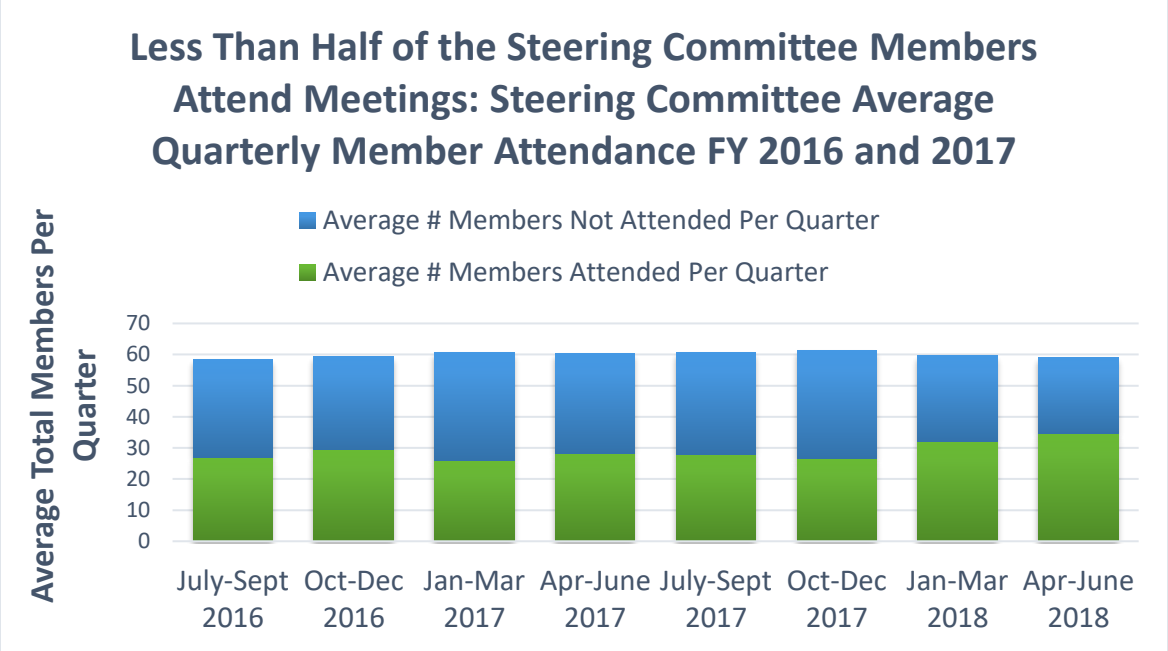
- **Accountability:** Unlike the county's Mental Health Board, whose members are appointed by the members of the Board of Supervisors, the Steering Committee members are appointed by the Behavioral Health Director to represent particular interests. There are no fixed terms for membership. In some cases, Steering Committee members may represent organizations that receive funding from MHSA programs, raising a perception about potential conflicts of interest. Even if members recuse themselves from making decisions in these areas, our interviews revealed a perception that the Steering Committee process reinforces the status quo.

- **Adding Time to Make Decisions**: The current structure followed by the county involves stakeholders at every step. There are monthly stakeholder meetings, committee meetings, public forums, avenues for public comment, and opportunities to provide input on drafts and review reports. All of this input is critically important. However, some of it seems duplicative because many individuals are involved in multiple committees, forums, and other meetings where input can be provided. As a result, this

may slow down the process of getting projects to the Board of Supervisors for approval. This could lead to delays in getting funding into the community for services.

- **Attendance:** In recent years attendance at the meetings has decreased significantly. As noted in Chart 4 below, only about 50 percent of members attend on average. The decline in attendance may also reflect a level of uncertainty about the role of the steering committee and the perceived value of participation in it. When attendance declines, there is also a concern about whether steering committee decisions are truly representative of the broader stakeholder community or skewed toward the interests of those who show up. This erodes the credibility and sense of legitimacy of the steering committee process.

Chart 4



- **Subcommittee Process:** The current subcommittee process used by Orange County has stakeholders participating in workgroups on areas that are part of MHSA. For example, there is a PEI subcommittee that is chaired by two individuals. This group meets regularly to discuss issues related to PEI and to make recommendations related to programming and funding in this area. The same issue may be aired in multiple forums by many of the same participants, which increases the time demands on stakeholder participants.

What Do Other Counties Do?

Other counties have adopted an approach that engages their stakeholders in a more advisory and less formal capacity. Indeed, of the four counties we contacted, none afforded their stakeholders with formal decision-making authority, as Orange County does. Examples of alternative approaches in these counties include:

- San Diego County: In San Diego, there are six advisory councils that are organized with a focus on specific populations (Adult System of Care, Children Youth and Families, Older Adult, Housing, Transitional Age Youth, and Cultural Competency Review Team). These councils have oversight over all behavioral health programs in their area of responsibility, not just those that are funded by MHSA. An Adult System of Care Council member advises on MHSA programs, but also on the broader array of mental health services that are provided to a particular population. This approach helps advisory committee members to better understand how MHSA programs and expenditures fit into the larger system of care.

- Los Angeles County: As originally conceived, the county's stakeholder committee's decision process was similar to Orange County's, and included voting on specific issues. However, that process was revised about two years ago when the committee was reorganized to serve in a more advisory role.

- Alameda County: Alameda County has a 21-member stakeholder group. The group is comprised of 25 percent providers, 25 percent family members, and 25 percent consumers. The composition of the remaining 25 percent remains open and flexible and positions are filled based upon need. A member of the steering committee group will be removed if more than three meetings are missed in a twelve-month period. Members serve fixed-length, staggered terms to assure continuity.

  The MHSA Stakeholder Group uses a structure consisting of three standing committees.
  - Steering Committee: A Steering Committee has at least five members, with representation from providers, consumers, and families. The Steering Committee develops meeting agendas and appoints ad hoc committees.
  - Membership and Orientation Committee: The Membership and Orientation Committee includes Consumer, Family, Provider, Mental Health Board representation, as well as BHCS staff.
  - Evaluation Committee.

- Santa Clara County: Santa Clara recently restructured their stakeholder committee. It is now composed of 25 non-voting members who are appointed by their Behavioral Health Director.

Recommendations:

- **Stakeholder Committee should be non-voting and advisory.** The role of the advisory committee would be to provide advice on funding and programmatic priorities as requested.

- **Appointment and Attendance.** The Behavioral Health Director should continue to appoint to the advisory committee, but we recommend the Director develop a policy on fixed length terms. In addition, a policy should be established to replace members who are consistently absent.

- **Broader Scope.** The scope of the non-voting stakeholder committee should be broader than just MHSA. It should be more inclusive of the county's Behavioral Health System and programming. The county could better utilize the experiences and expertise of these individuals by setting up a structure that is not program specific but rather population specific. This would provide the opportunity for the county to utilize the experiences and expertise of stakeholders for mental health programming beyond MHSA and across county programs.

  As an example, the San Diego model is targeted to populations (i.e., youth, adults), and its scope is not limited to MSHA funded programs. For instance, a community member that is part of the MHSA advisory committee would be part of the Children, Youth and Families Council. In this position, this individual would provide advice on MHSA funding and programming along with other non-MHSA funded programs that impact this population, as requested by the Health Care Agency or others. This configuration would best utilize the expertise of the committee members.

- **New Member Orientation.** Develop and consistently use a standard orientation packet and process with new stakeholders involved. An annual refresher of all committee members would also be useful to bring them up to date on any new practices that may be implemented.

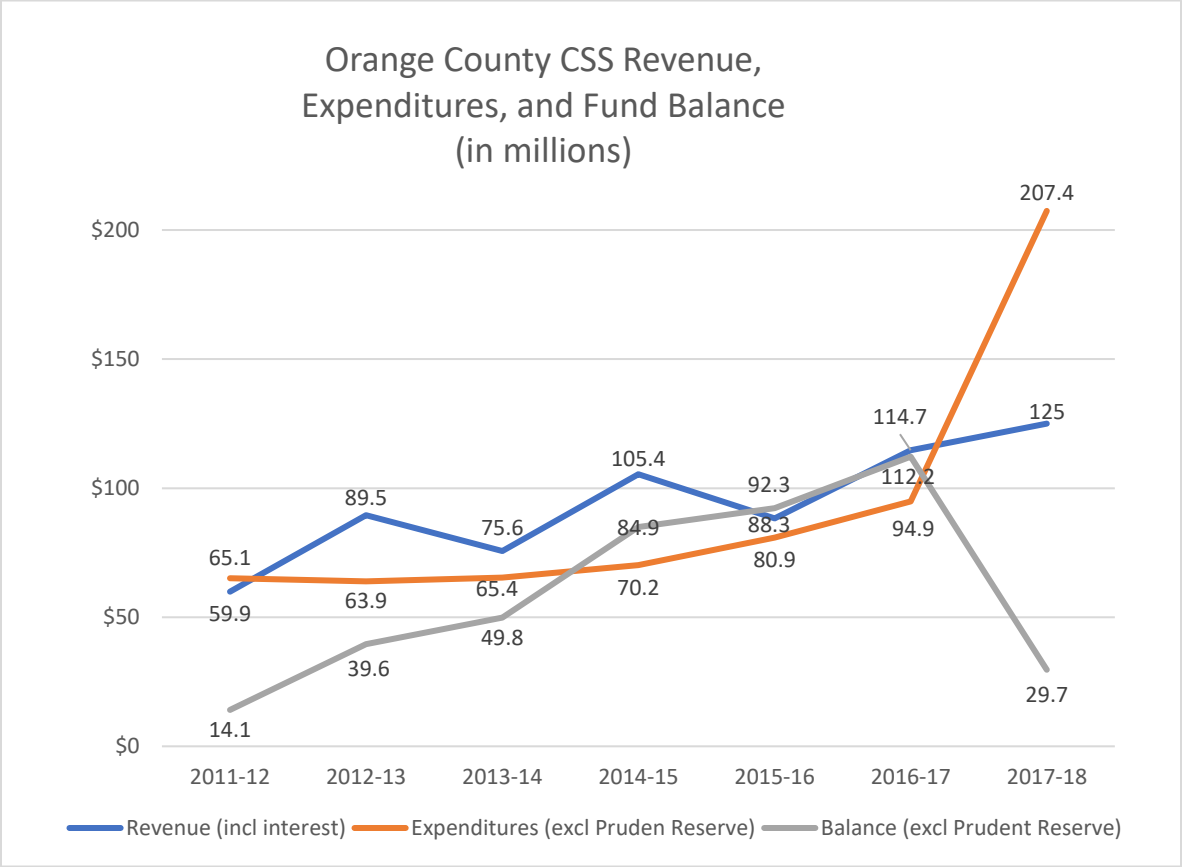
- **Shorten and Streamline Process**. The county should examine its process for providing stakeholder input and, where it makes sense, attempt to streamline such opportunities and/or shorten timelines for input in order to get projects into the community quicker.

Issue #2: Accelerating and Streamlining Expenditure Decision Making Process

The county's MHSA process for expenditure decision making is cumbersome, complex and slow to respond to the wide swings in MHSA revenue discussed earlier. In addition, expenditure decisions should be based on an assessment of whether new revenues reflect a one-time spike that should be committed to one-time projects or an ongoing increase that could be allocated for ongoing programs.

As seen in Chart 5 below, the amount of Orange County's unspent MHSA funds has increased significantly in relationship to spikes of increased revenue.

Chart 5



According to the Health Care Agency, unspent CSS funds rose sharply, in part due to large revenue spikes in FYs 2012-13 and 2014-15. In each of these FYs, Orange County received $30 million more than the prior year. As noted in the MHSA Fact Sheet, "it has taken time to plan, strategize and implement needed programs to spend these additional dollars."[11]

In the past, when counties received unexpected new revenues, counties sought input from the community and the Stakeholder Committee on projects that should be considered for the new funding. Counties we spoke to address the possibility of an unexpected influx of funds by maintaining a list of possible projects from stakeholder inputs so these projects can quickly be explored (and approved) in the case of an influx of unexpected MHSA revenue. As described,

[11] Orange County MHSA Fact Sheet, Prepared April 2018

this process allows for the county to make decisions quickly about how to spend the funding and to start the necessary internal processes to get the funding out into the community.

Recommendation:

- Structure priorities for new funding in such a way that if new (additional) funding becomes available, modifications to the three-year plan can be implemented quickly.

Issue #3: Analytics: Role of Data in Setting Priorities and Decision Making

In addition to transparency and accountability, effective decision making relating to priority setting and expenditures requires the systematic use of objective data. Data is a tool that policy-makers and stakeholders can use to inform decisions. Community's needs and values, as reflected by local elected officials, county staff, and stakeholders, are also critical factors in the process. While anecdotes and personal testimonials can help illustrate needs or suggest program effectiveness, rigorous data collection systems that produce reliable and meaningful data are especially critical to understanding needs and outcomes.

Orange County's Department of Behavioral Health staff has demonstrated a commitment to systematic approaches for gathering data in key areas:

- **Research Planning.** Orange County's Department of Behavioral Health launched a research planning initiative that was outlined as part of a May 2015 evaluation plan that commissioned both a needs and gap analysis as well as a Net Benefit analysis. The Needs and Gap Analysis was intended to estimate the need for mental health services in Orange County, the use of mental health services, and disparities in access to mental health services by demographic characteristics and geographic location. The Net Benefit Analysis was proposed to provide more detail on the mission, approach, and outcomes of MHSA services. The goal of this research was intended to provide insight into the state of mental health services in Orange County and the role and value of mental health services that were implemented under the MHSA.

- **Needs Assessment.** In May 2018, the Orange County Health Agency released a needs and gap analysis conducted by the Health Services Research Center at the University of California, San Diego. The report assesses the current state of mental health need and unmet need in Orange County.[12] The report identified a prevalence rate of 6.7 percent for mental health needs among adults with about half reporting that they had not received treatment for their symptoms over the past year from a health professional. Of the 4.2 percent of adolescents with a mental health need, nearly two-thirds did not receive treatment in the past year. Among the homeless adults surveyed in the 2017

[12]http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/Orange_County_MHSA_Program_Analysis_May_2018.pdf

Point-in-Time Survey, 12 percent were reported as having serious mental health needs, and two-thirds of homeless adults with serious mental illness remain unsheltered. Most reported they had never accessed treatment. The UCSD report highlighted substantial variations in health needs among various demographic groups with the goal of identifying geographic disparities.

- **Program Evaluation**. Evaluating the effectiveness of programs that serve individuals with mental illness has multiple challenges, but the Agency has a strong commitment to employing methodologies that will yield useful data. This is particularly true in the evaluation of the county's Full-Service Partnership (FSP) program. Evaluation data for participants in this program include:

    - Days spent in Psychiatric Hospital;
    - Number of Mental Health Related Emergency Events;
    - Days spent in Unsheltered Homelessness;
    - Days spent in Emergency Shelter;
    - Days spent in Independent Living (TAY, Adults, Older Adults);
    - Days spent in Out-of-Home Placement (Children);
    - Days spent Incarcerated;
    - Number of Arrests;
    - Days Employed (TAY, Adults, *Older Adults*); and,
    - Percent with Good/Very Good/(Improved) School Grades and Attendance.

The evaluation of other MHSA-funded programs is less rigorous, often using a consumer satisfaction survey.

Enterprise Data Warehouse. As part of its approved strategic initiatives for FY 2018-19, HCA is moving toward the implementation of an Enterprise Data Warehouse to standardize, consolidate, integrate, and to better protect the Agency's data to better serve the information needs. The goals of the Warehouse include:

- Program trend analysis across multiple years;
- Use of forecasting software for fiscal projections, estimating numbers to be served, etc.;
- System level analysis (i.e., modeling how clients move through system, etc.);
- Comparisons of performance and utilization *across* programs; and,
- Periodic net benefit analyses.

Recommendation:

- **Create a Dashboard.** In setting expenditure priorities, decision makers should consider establishing policy objectives that are based on measurable indices. Looking at trends

or comparing how Orange County compares with similar counties can provide an added context for assessing competing needs.

We suggest that the county create a dashboard containing a menu of the key indicators that provide both a reference point for current efforts as well as trends. This information can help identify underlying needs and program effectiveness. If trends, positive or negative, the dashboard can help raise questions about causes and policy changes that might be needed. Comparisons with other large counties can also yield valuable information.

To provide an example of what a dashboard for Orange County might include, CalHPS has (1) gathered a variety of publicly available data sets and (2) included an analysis of trends and comparisons with other counties. These key indicators are presented in Appendix 3 and include the following:

- **Key Indicator 1**: Penetration rates and trend for both adults and youth who have received at least one county specialty mental health service in the fiscal year, compared to the rates and trends in the 10 largest counties
  - For the past four years Orange County has had one of the lowest penetration rates compared to the ten most populous counties.
- **Key Indicator 2**: Hospital Emergency Department for individuals who present with a mental health diagnosis, including county-level trends and comparisons with other large counties
  - From 2011 to 2015, Orange County saw a 20 percent increase in selected mental health conditions in emergency departments. Of the ten most populous counties, only Contra Costa and San Diego had higher growth in these mental health conditions in emergency departments.
- **Key Indicator 3**: Inpatient discharges for both adults and children with step down services with seven days of discharge, including county-level trends and comparisons with other large counties
  - In the most recent year of data (FY15-16), Orange County saw a significant increase in these inpatient discharges going from one of the lowest counties to the middle of the ten most populous counties.
- **Key Indicator 4**: Hospital inpatient administration days per unique beneficiary
  - Orange County's trends over time are volatile, but the most recent data point places the county in the middle of the other ten large counties.
- **Key Indicator 5**: Mean number of days between inpatient discharge and step-down service
  - With the exception of the most recent data point, Orange County's mean number of days has generally been one of the highest among the large counties.
- **Key Indicator 6**: Trend for crisis assessment team calls including “5150s” (Orange County only)

- Orange County's 5150s are trending relatively flat, while the number of all calls has grown steadily in the past five years

- **Key Indicator 7**: Unsheltered Homeless
  - Orange County's point-in-time homeless count report shows approximately 12 percent of homeless adults self-identified as having a serious mental illness. The percent of homeless individuals who are unsheltered has increased over time, from 39 to 54 percent.

Additional indicators are provided in Appendix 4.

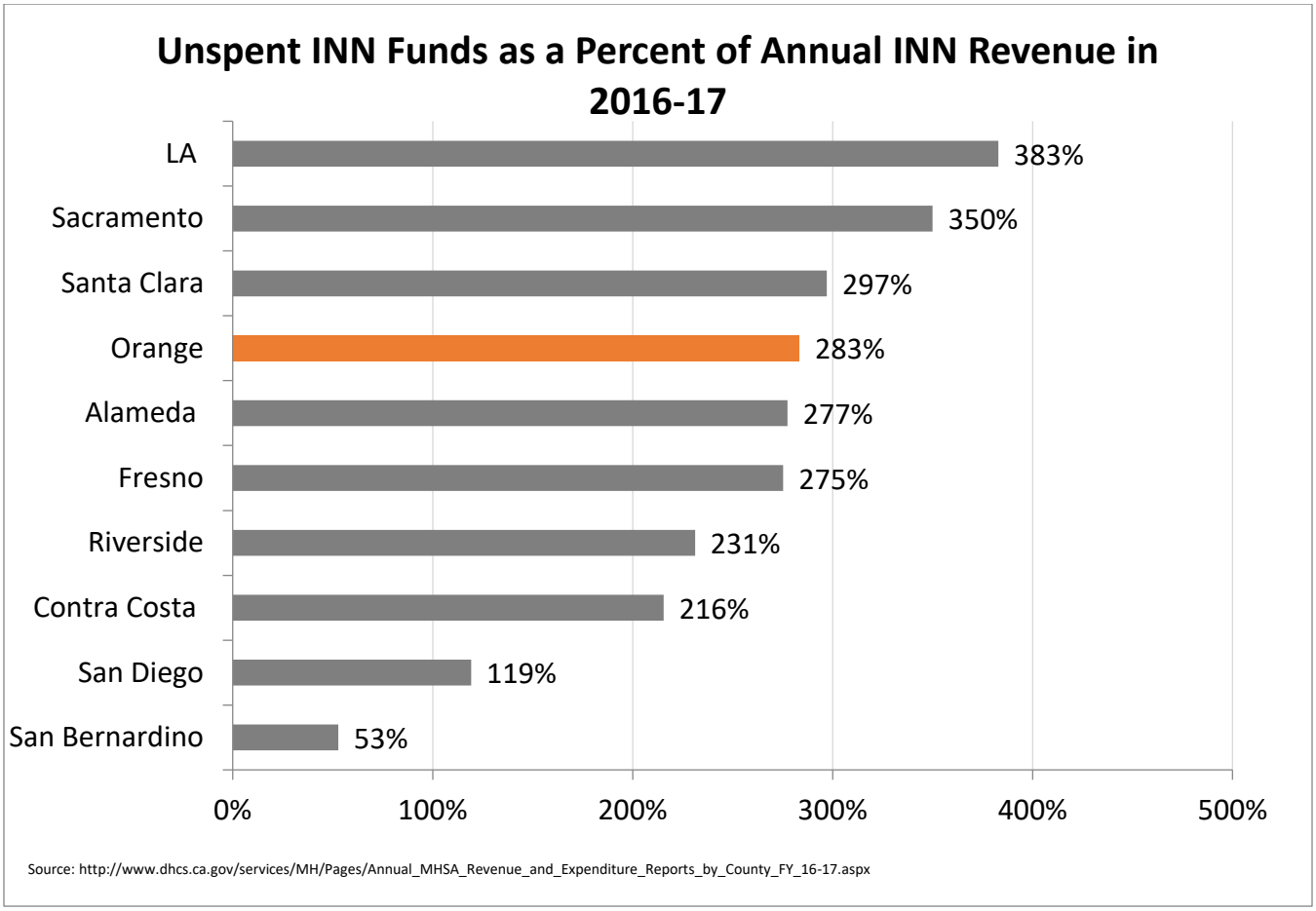
Issue #4: Decision-Making Process on Innovation Fund Expenditures

The current process for developing Orange County's Innovation Fund programs is a source of concern. The MHSA designates five percent of a county's allocation to demonstrate the effectiveness of innovative programs that contribute "new best practices for mental health services and supports."[13] Counties are required to submit their innovation fund proposals to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for consideration and approval.

As indicated in Chart 6 below, unspent Innovation Fund revenue has been growing and in FY 2016-17 had reached 283 percent of INN revenues received that year in Orange County. Other counties have accumulated comparable unspent revenue, presumably due to similar issues with spending these funds.

[13] Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA, Article 2 Definitions

Chart 6



Source: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx

Based on new state requirements, INN funds that are unspent for more than three years will revert back to the state. We understand that HCA staff are developing multiple INN proposals in order to avoid a potential reversion in FY 2019-20. This risk is due in part to the specificity around the term "innovation" relative to MHSA. It also stems from unspent funds intended for INN proposals that were denied by the MHSAOC in October 2016. At that time, three proposals related to employment programming were denied.

Over the past eight years, Orange County has submitted 20 INN proposals to the MHSOAC and 17 have been approved. Four of the nine INN projects that have been completed were deemed successful and subsequently have been funded on an ongoing basis with funding from the other MHSA accounts. However, Orange County is not alone in finding it challenging to develop INN proposals that are likely to be approved by the MHSOAC.

A large problem with the development of INN projects has been the definition of innovative. Its definition is described in the state regulations as follows:

"Section 3910. Innovative Project General Requirements.

(a) The County shall design and implement an Innovative Project to do one of the following: (1) Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention. (2) Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population. (3) Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

(b) A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach, consistent with subdivision (a)(2) above and with section 3930(c)(3). For example, the change can include specific adaptation(s) to respond to unique characteristics of the County or a community within the County such as an adaptation for a rural setting of a mental health practice that has demonstrated its effectiveness in an urban setting, or vice versa. (1) For purposes of this section, a mental health practice is deemed to have demonstrated its effectiveness if there is documentation in mental health literature of the effectiveness of the practice. (A) "Mental health literature" refers to any report, published or online, including, but not limited to, peer-reviewed articles, nationally circulated (online or print) articles, reports of conference proceedings, program evaluation reports, and published training manuals."[14]

Orange County is struggling to spend all of its INN funding due to multipronged challenges.

- **Long Process.** The innovation project development process can be lengthy and resource intensive. The county must work with stakeholders and internally to identify a need in the county that would meet the strict requirements for "innovative." Once such a need is identified, then the county must prepare the proposal, obtain approval from the Steering Committee, Mental Health Board, and Board of Supervisors. At that point, the county can request a date for presentation to the MHSOAC. This process from start to finish (approval by MHSOAC be nine to twelve months long. It can be longer depending on how many ideas are received from the community because each promising idea would require an individual proposal to the state.

- **County Contracting**. If the MHSOAC approves the project, the county's lengthy contracting process can create a challenge in the context of INN time limitations. Currently, the Board approval process for contracted programs is to approve an initial contract for three years, with the option to return twice for one-year extensions (i.e., maximum five years). This is internally referred to as the "3 +1 +1 requirement" for contracts. Innovation regulations allow projects to last a maximum of five years, and Orange County typically proposes five-year projects to allow time for procurement and start up. Innovation staff must divide their time between developing new proposals and

[14] Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA, Article 9 Innovation

the local renewal process at the end of Years 3 and 4 for any project that exceeds three years. Additionally, INN projects can take between one and a half and two years to complete the procurement, contracting, and project start up process. Thus, there may only be one year of performance outcome data available for the first contract renewal that is currently in place.

Currently, Agenda Staff Reports (ASR) in Orange County must be routed a minimum of six weeks prior to the Board of Supervisors meeting where the project approval will be considered with all attachments included. Orange County also requires that a final (unsigned) copy of the project contract, MOU or Participation Agreement (PA), if joining a multi-county collaborative operated through a Joint Powers of Authority, must be attached as an appendix to the ASR prior to being placed on the Board agenda. The MHSOAC additionally requires that an Innovation project proposal be approved by the local Board of Supervisors prior to seeking MHSOAC approval. Due to this required sequence of events, providing a final MOU or PA, in particular, with the ASR can limit Orange County's ability to join cross-county collaboratives, because other counties do not require unsigned MOUs, contracts, or PAs as part of their ASR process and they do not typically spend time on developing the PA and MOU prior to receiving MHSOAC approval. Los Angeles County reportedly has an arrangement with MHSOAC to obtain provisional approval from the Commission and then receive their Board approval.

- **Lack of Clarity on What is "Innovative**." The definition of "innovation" and what is innovative appears to be a fundamental sticking point in the project development process. Counties report this ambiguous definition of innovation has made it challenging for many to develop projects.

- **Project Deemed Not "Innovative."** There have been instances where Orange County brought a proposal to the Commission only to be told that their proposal was not innovative so, therefore, they would not be able to receive funding for the project. Given that Commission members must vote to approve projects, there is the possibility that individual interpretations of what is innovative are impacting decisions. At this point, the county has often spent upwards of nine to twelve months developing the project idea—a process which involves significant time investment by county staff and stakeholders.

Orange County Case Study in Innovation Project Challenges: To illustrate the challenges with developing and receiving approval for innovative projects, we asked staff at the Health Care Agency to provide us with an example of an experience they have had.

Example of Project Idea in Conflict with Definition of "Innovative." Beginning in November 2017, Orange County started to develop a proposal to create a comprehensive online directory of housing resources in Orange County to help meet the needs of the county's seriously mentally ill homeless population. The Health Care Agency's Innovation staff initiated the local community planning process to develop the

e-Housing project idea to create a single, online directory of existing housing resources and use an algorithm to automatically match individuals to the appropriate level of housing and facilitate placement. Orange County spent almost six months developing this idea. However, because Santa Clara County posted a similar housing match proposal for 30-day public comment in May 2018, Orange County staff raised a concern that the proposal would no longer be viewed as "innovative" since it would no longer be a new project idea that had been untested elsewhere. At this time, because of this finding, Orange County staff stopped the development of this INN project.

Addressing the INN Challenges. There are activities the county is currently engaged in to use available INN funds. For example, the county is exploring other approved statewide project collaboratives that they could join.

The county is working to schedule a community planning process on project ideas that can be rapidly developed and presented to the state by June 30, 2019. There will be meetings in October 2018 to explore projects around stigma reduction, social media, and mental health. If the projects are approved by the state, the projects will need to be implemented quickly in order to get dollars out into the community. There are processes that the county could address and change which could decrease the amount of time it takes for the projects to become services in the community.

The MHSOAC recognizes the challenges that counties face in developing new ideas to test with their innovation funding. The Commission has sponsored a series of gatherings to help stimulate the creation of innovative ideas which Orange County's staff has participated in. The state Commission can encourage the development of innovative ideas that can be shared with counties to test out. The state staff have indicated that they are able to assist counties from the earliest stages of development to help ensure that the efforts to design innovative approaches are on track and will result in proposals that can gain approval by the Commission. Orange County's staff has already reached out to MHSOAC staff to begin discussions on working together to develop innovative projects.

Recommendations:

- **Front-End Collaboration**. Orange County Health Care Agency staff should continue to work with MHSOAC staff to identify and develop innovative projects that can gain approval by the Commission.

- **Streamlined Board Approval Process**. Implement a single Board of Supervisors approval for INN projects up to a maximum of five years, rather than the current 3 +1 +1 requirement described above.
    - This will allow INN staff to focus resources on the development of new proposals, rather than focusing on the renewal process at the end of Years 3 and 4 for projects that exceed three years.

- **Seek Provisional Approval from Board.** Remove the requirement that a finalized, unsigned contract/MOU/Participation Agreement must be attached to the ASR prior to Board approval. This requirement is particularly limiting in joining cross county collaboratives.
    - Los Angeles County apparently has an arrangement with MHSOAC to obtain provisional approval from the Commission and then receive their Board approval. Orange County should explore this option to see if it assists in the sequencing and timing of INN project approval and implementation.

- **Consider Enhanced INN Staffing.** Additional temporary staffing may be required to develop INN proposals that can help avoid the imminent risk of INN fund reversion. These temporary positions would help to manage the various facets of the development of an INN project (i.e., new proposal development and/or community planning; due diligence to ensure that the project meets the state's definition of innovation; procurement and contracting; project start-up/development, implementation and data collection; ongoing evaluation and written reports; administrative oversight, etc.). This could take place during a critical period over the next two years, when there will be a need to increase the number of proposals to be vetted, developed, and approved by the MHSOAC in order to avoid reverting INN funds. Once the available unspent INN fund balance is allocated and expended on new projects, this increased staff support may no longer be necessary and could be reassessed at that time.

Implementation – Procurement process and management of contracts

Once decisions on expenditures for programs have been made, it is critical that the funds get to the approved vendors and providers quickly so that services can be received in the community. The county and its MHSA vendors must work together as a team to ensure that services are being provided to those in need. This team approach requires constant communication between the county and its vendors to ensure that the funds allocated are being spent in the manner intended.

Issue #1: *Engaging with vendors and providers*

In Orange County, approximately 50 percent of the MHSA contracts are with outside vendors. Innovation projects are 100 percent contracted with outside vendors for services. Critical to the success of the programs is a good working relationship between the county and the service providers. We heard from vendors that, in the past, the Behavioral Health Director met quarterly with them to gather information on what was working and what wasn't in order to help improve communication and programming for MHSA. Sometime in the last three to five

years, those meetings stopped occurring. The majority of the vendors that we spoke to believe that there is great value is these types of meetings; vendors benefit from the department hearing from them directly in a small meeting setting and vendors benefit from the opportunity to interact with their fellow vendor colleagues.

All of the vendors CalHPS spoke to had high praise for the contracting staff. However, there was a belief that the process is disjointed because the contracting authority for MHSA is through the Agency (with the contracts division) and not the Behavioral Health Department where program oversight staff for MHSA reside. Vendors with experience in multiple counties indicated that Orange County was unique in having a bifurcated process that split the contracting function from program oversight responsibility. We were advised that there have been situations when Behavioral Health staff was not aware of RFPs coming out from the Health Care Agency. Additionally, while program staff and contracting staff have different roles and responsibilities with the vendors, there was a general sense that the knowledge base of both should be comparable given the important role that contract managers have.

Vendors also spoke about a process for reporting that is very detailed, granular, and occurs monthly. This includes frequent site visits, sometimes as often as once a week. Additionally, vendors with multiple contracts could be working with two or three different contract managers--contract managers are not typically assigned across organizations, but rather according to MHSA category (CSS funded project vs PEI). Each contractor could be asking for similar information about the organization in different ways if there is a lack of consistency in rules and requirements for how information is reported back to the project contract manager.

Every other county we spoke to--San Diego, Alameda, Los Angeles and Santa Clara engage with vendors regularly through a scheduled meeting with a leader in behavioral health to hear about challenges, improvements, programs, and services. In addition, these counties interactions with vendors involve the day-to-day work that the contracts manager does with the vendor.

Recommendations:

- Establish a formal and informal engagement process with vendors. The formal process could include quarterly or semi-annual meetings between vendors and Health Care Agency Leadership and the Behavior Health Director. Informal meetings could help facilitate a more encouraging environment for gathering comments and ideas from vendors for improving the process.

- Spend some time studying how other counties manage MHSA contracts to consider the possibility of streamlining Orange County's system to improve efficiencies.

- Establish a process to keep all county staff involved in the MHSA program informed of RFP's before they are released to the public. One way would be to release an internal (county) email bulletin listing all upcoming RFPs no less than 14 days before release.

- Develop a process to make contract managers' communications with vendors more uniform, including what information is required for monthly reporting.

- Consider having one contract manager manage all MHSA contracts with the same vendor in order to help with uniformity and continuity.

Issue #2: *Challenges with the RFP and Contracting Process*

Vendors reported that the RFP to award process is long and tedious. CalHPS learned that the process can take as few as six months, but, in some cases, the process took up to two years. Multiple steps to the process mean that there are multiple opportunities for delays. Concerns were expressed about delays at different stages of the process, ranging from the beginning of the process with the release of the RFP all the way to late-process delays due to issues being raised by the Board of Supervisors. A reoccurring theme CalHPS heard is that while staff are very responsive and competent, many are just wearing "too many hats" and handling too many RFPs or contracts to be able to stay fully on top of it all.

Another vendor concern related to the lack of a boilerplate RFP that would simplify the process. Currently, there are significant variations of information vendors are being asked to provide. Nonetheless, CalHPS also heard that the RFPs are clearly written and that opportunities have been created for interested vendors to attend meetings to ask questions about the RFP prior to submission; these processes are extremely useful and should continue. Vendors also appreciated that the applications are now available online. Vendors told us that other counties put the dollar amounts available for the specific RFP, and they find that very helpful to know as they plan their submission.

Extensive compliance requirements are another challenge and may constrain the ability of smaller vendors to become contractors. The limitations placed on administrative costs was identified as an area the county could look at further in order to allow a vendor to have more funding available to them to use for the administrative expenses associated with compliance, including insurance requirements and data capacity and data infrastructure requirements.

Another area of concern identified is that no contract updates are given to the vendor. When a vendor is selected, they sign a three-year contract with the opportunity for two, one-year renewals. The contracts, however, do not include increases to cover the cost of cost-of-living adjustments (COLA) for the contractor's staff. CalHPS understands that other counties build such increases into their contracts. Vendors reported that the inclusion of a COLA in a MHSA contract would help retain key staff and help maintain service continuity.

Currently, there is not a process in place to recognize if there is an increase in the number of patients being served over the course of the contract. We understand that often a vendor will commit to serving a set number of patients per year, but the actual level of service may be much higher. The current process requires the vendor to use the contracted allotment even

though more patients have been served. Additionally, there is no broader process to reconsider funding levels for vendors if their performance does not meet county standards. Both performance and capacity do not change the vendors' funding levels while under contract. There is a sense expressed by some vendors that performance outcomes do not impact funding (either current or future), because the level of funding awarded in the contract remains the same regardless of performance.

Recommendations:

- **Master Contract.** Develop a Master Contract for vendors that have more than one MHSA contract with specific scopes of work for each service they are providing. Los Angeles and Alameda County do something similar and it helps streamline the processes, paperwork and interactions with the county. This could allow for one contract for that vendor which lays out all of services they are to provide and under what terms.

- **Address Staffing Needs.** Increase staffing or reprioritize MHSA in contracts department in order to move through the RFP process to implement programs quicker.

- **Multi-Year Budgeting.** Include in the RFP process the request for a three-year or five-year budget to give the vendor an opportunity to provide estimates of how much services will really cost over the course of the contract.

- **Vendor Performance**. Consider modifications to contracts based on over or under performance. In the event of over performance, if the county has available funds, there could be a process created to allow for additional funds to be available under the contract to support the vendor's work.

Summary of Recommendations

1. BUDGET TRANSPARENCY

✓ **Budget Display – How Much is Available for Expenditure Decisions?**

Recommendations:

- **Budget Display.** Establishing a clear, consistent, and credible budget display for MHSA funds is a crucial step toward restoring confidence and transparency in the process. Specifically, we recommend the following:

    - **Prudent and Operating Reserve Levels and Rationale.** While the level of the Prudent Reserve is now set as a matter of law, the County should consider whether the funding available in the Prudent Reserve sufficiently mitigates the risk of program cutbacks during a recession. Additional funds can be held uncommitted as a further hedge against revenue falls, but not with the protection that the Prudent Reserve enjoys from possible reversion if the funds remain unspent for too long. The County fiscal staff should assess whether the risks of program reductions in some future recession are sufficiently great to justify running some risk of fund reversion and recommend a policy of reserving additional funds beyond the level of the Prudent Reserve as an operating reserve to provide interim assistance before the Prudent Reserve funds can be accessed. County staff should also get clarification from the state as to what the county must do to conform to the new 33 percent Prudent Reserve requirement.

    - **How Much Is Available for Expenditure?** Develop a budget display that clearly allows policy-makers and stakeholders to understand how much MHSA funding is available for expenditures for the fiscal year. This display should clearly delineate the Prudent Reserve, an operating reserve, and funds that are obligated but unspent. There should also be a consistent process used for updating this display throughout the year as needed.

    - **Continue CEO Role.** Continue the process of CEO's office managing the MHSA budget and providing regular updates to the MHSA steering committee, Mental Health Board, and all other interested parties including biannual budget updates. Having dedicated staff working on this important issue will help streamline concerns and will create a process that should lead to more timely and accurate information sharing.

✓ **What programs are being funded?**

Recommendations:

- **Standardized Template and Program Inventory**. Create a standardized template and inventory of programs that receive MHSA funds. Maintain a separate list of non-MHSA funded mental health programs in the county.

- **Four Broad Program Categories.** Categorize each of the funded MHSA programs under the following four broad areas:
  - Crisis Mental Health Services,
  - Treatment Services,
  - Prevention,
  - Support Services, and
  - Training and Infrastructure.

- **Program Descriptions.** Provide a description for each MHSA funded program that includes a brief summary of revenue source and expenditure information for prior, current, and proposed fiscal years; administrative costs; locations of the programs and services; the number of people served at each location; and outcome or evaluation information if available.

2. DECISION MAKING ON MHSA PRIORITIES AND EXPENDITURES

✓ **Role of Stakeholders**

Recommendations:

- **Stakeholder Committee should be non-voting and advisory.** The role of the advisory committee would be to provide advice on funding and programmatic priorities as requested.

- **Appointment and Attendance.** The Behavioral Health Director should continue to appoint to the advisory committee, but we recommend the Director develop some policy on fixed length terms. In addition, a policy should be established to replace members who are consistently absent.

- **Broader Scope.** The scope of the non-voting stakeholder committee should be broader than just MHSA. It should be more inclusive of the County's Behavioral Health System and programming. The county could better be utilizing the experiences and expertise of these individuals by setting up a structure that is not program-specific but rather population-specific. This would provide the opportunity for the county to utilize the experiences and expertise of stakeholders for mental health programming beyond

MHSA and across county programs.

As an example, the San Diego model is targeted to populations (i.e., youth, adults), and its scope is not limited to MSHA funded programs. For instance, a community member that is part of the MHSA advisory committee would be part of the Children, Youth and Families Council. In this position, this individual would provide advice on MHSA funding and programming along with other non-MHSA funded programs that impact this population, as requested by the Health Care Agency or others. This configuration would best utilize the expertise of the committee members.

- **New Member Orientation.** Develop and consistently use a standard orientation packet and process with new stakeholders involved. An annual refresher of all committee members would also be useful to bring them up to date on any new practices that may be implemented.

- **Shorten and Streamline Process**. The county should examine its process for providing stakeholder input and, where it makes sense, attempt to streamline such opportunities and/or shorten timelines for input in order to get projects into the community quicker.

✓ Accelerating and Streamlining Expenditure Decision-Making Process

Recommendation:

- Structure priorities for new funding in such a way that if new (additional) funding becomes available, modifications to the three-year plan can be implemented quickly.

✓ Analytics: Role of Data in Setting Priorities and Decision-Making

Recommendation: Create a mental health dashboard. We suggest the creation of a dashboard that contains a menu of the key indicators that provide both a reference point for current efforts as well as trends.

✓ Decision-Making Process on Innovation Fund Expenditures

Recommendations:

- **Front-End Collaboration**. Orange County Health Care Agency staff should continue to work with MHSOAC staff to identify and develop innovative projects that can gain approval by the Commission.

- **Streamlined Board Approval Process**. Implement a single Board of Supervisors approval for INN projects up to a maximum of five years, rather than the current 3 +1 +1 requirement described above.

- This will allow INN staff to focus resources on the development of new proposals, rather than focusing on the renewal process at the end of Years 3 and 4 for projects that exceed three years.

- **Seek Provisional Approval from Board.** Remove the requirement that a finalized, unsigned contract/MOU/Participation Agreement must be attached to the ASR prior to Board approval. This requirement is particularly limiting in joining cross county collaboratives.
  - Los Angeles County reportedly has an arrangement with MHSOAC to obtain provisional approval from the Commission and then receive their Board approval. Orange County should explore this option to see if it assists in the sequencing and timing of INN project approval and implementation.

- **Consider Enhanced INN Staffing.** Additional temporary staffing may be required to develop INN proposals that can help avoid the imminent risk of INN fund reversion. These temporary positions would help to manage the various facets of the development of an INN project (i.e., new proposal development and/or community planning; due diligence to ensure that the project meets the state's definition of innovation; procurement and contracting; project start-up/development, implementation and data collection; ongoing evaluation and written reports; administrative oversight, etc.). This could take place during a critical period over the next two years, when there will be a need to increase the number of proposals to be vetted, developed, and approved by the MHSOAC in order to avoid reverting INN funds. Once the available unspent INN fund balance is allocated and expended on new projects, this increased staff support may no longer be necessary and could be reassessed at that time.

3. Implementation – Procurement process and management of contracts

✓ Engaging with vendors and providers

Recommendations:

- Establish a formal and informal engagement process with vendors. The formal process could include quarterly or semi-annual meetings between vendors and Health Care Agency Leadership and the Behavior Health Director. Informal meetings could help facilitate a more encouraging environment for gathering comments and ideas from vendors for improving the process.

- Spend some time studying how other counties manage MHSA contracts to consider the possibility of streamlining Orange County's system to improve efficiencies.

- Establish a process to keep all county staff involved in the MHSA program informed of RFP's before they are released to the public. One way would be to release an internal (county) email bulletin listing all upcoming RFPs no less than 14 days before release.

- Develop a process to bring more uniformity in how contract managers communicate with the vendors they are working with including what information is required for monthly reporting.

- Consider having one contract manager manage all MHSA contracts with the same vendor in order to help with uniformity and continuity.

✓ Challenges with the RFP and Contracting Process

Recommendations:

- **Master Contract.** Develop a Master Contract for vendors that have more than one MHSA contract with specific scopes of work for each service they are providing. Los Angeles and Alameda County do something similar and it helps streamline the processes, paperwork, and interactions with the county. This could allow for one contract for that vendor which lays out all of services they are to provide and under what terms.

- **Address Staffing Needs.** Increase staffing or reprioritize MHSA in contracts department in order to move through the RFP process to implement programs quicker.

- **Multi-Year Budgeting.** Include in the RFP process the request for a three-year or five-year budget to give the vendor an opportunity to provide estimates of how much services will really cost over the course of the contract.

- **Vendor Performance**. Consider modifications to contracts based on over or under performance. In the event of over performance, if the county has available funds, there could be a process created that allows for additional funds to be available under the contract to support the vendor's work.

About the Authors

- **Charity Bracy** has over 20 years of experience in the non-profit and government sector serving as a policy adviser to a U.S. Senator on health care issues, Vice-President of a statewide trade association, and as a consultant providing strategic advice on federal health care programs and hospital financing. She is a CalHPS's Senior Advisor.

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About California Health Policy Strategies (CalHPS), LLC.
CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.

Appendix 1: Budget Template

County of Orange
Summary of Mental Health Services Act Funding, Fund 13Y
Fiscal Year 2018-19 (As of August 2018)

Purpose: The table below summarizes the revenue, expenditures, and obligations for each of MHSA's components and provides estimated

					Transfers from CSS			
MENTAL HEALTH SERVICES ACT FY 2018-19		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**Total**	**Prudent Reserve**
Carryover of Funds from FY 2017-18		134,567,157	32,808,649	33,383,653	-	1,316,125	202,075,584	70,921,582
Prior Period Adjustments	(1)	(32,656,367)	(4,823,085)	(3,470,137)	-	(843,803)	(41,793,392)	
							-	
RESTATED Carryover funds from FY 2017/18		**101,910,790**	**27,985,564**	**29,913,516**	**-**	**472,322**	**160,282,192**	**70,921,582**
Projected MHSA Allocation for FY 2018-19		117,925,360	29,481,340	7,758,247	-	-	155,164,947	
Projected Interest Revenue for FY 2018-19		1,416,724	509,460	207,740	-	-	2,133,924	
Projected Transfers from Community Services and Supports to Other MHSA Subaccounts to Cover Approved Project Expenses	(2)	(25,154,294)	-	-	5,150,282	20,004,012	-	
Total Projected Funding Available for FY 2018-19		**196,098,580**	**57,976,364**	**37,879,503**	**5,150,282**	**20,476,334**	**317,581,063**	**70,921,582**
Total Projected Expenditures for Approved Projects per MHSA Plan		123,400,415	30,044,713	10,343,474	4,364,646	17,352,825	185,506,073	
Anticipated Program Related County Costs		22,212,075	5,408,048	1,861,825	785,636	3,123,509	33,391,093	
Total Projected Program and Administrative Costs		**145,612,490**	**35,452,761**	**12,205,299**	**5,150,282**	**20,476,334**	**218,897,166**	**-**
Projected Carryover of FY 2018-19 Available Funds		**50,486,090**	**22,523,603**	**25,674,204**	**-**	**-**	**98,683,897**	**70,921,582**
Pending Obligations or Adjustments	(3)							
Purchase of Site for Co-Located Behavioral Health Services		(7,723,934)	-	-	-	-	(7,723,934)	
Board Approved Allocation for Housing		(55,000,000)	-	-	-	-	(55,000,000)	
Release of amount held in liability account which per AB114 are no longer due back to the State			243,837				243,837	
Adjustment required per State to reclassify a portion of Prudent Reserve Funds back to PEI			11,343,034				11,343,034	(11,343,034)
Total for Pending Obligations and Adjustments		**(62,723,934)**	**11,586,871**	**-**	**-**	**-**	**(51,137,063)**	**(11,343,034)**
ADJUSTED Anticipated Carryover of FY 2018-19 Available Funds Less Obligations/Adjustments		**(12,237,844)**	**34,110,474**	**25,674,204**	**-**	**-**	**47,546,834**	**59,578,548**
Estimated New Revenue for FY 2019-20	**(4)**	**121,939,586**	**30,640,176**	**8,136,876**	**-**	**-**	**160,716,638**	
Projected Available Funds for FY 2019-20		**109,701,742**	**64,750,650**	**33,811,080**	**-**	**-**	**208,263,472**	**59,578,548**

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19 (As of August 2018)
Community Services and Supports (CSS)

Purpose: To report on the revenues and expenditures by MHSA component and identify any pending items to provide information needed for strategic planning and programming.

		FY 16/17	FY 17/18	FY 2018/19		
		Actuals	Actuals	Budget	Actuals	Projections
Carryover of Funds from Prior Fiscal Year	(1)	**97,583,337**	**117,365,707**	**101,910,790**	**134,567,157**	**101,910,790**
Adjustment for Prior Year Expenditures paid in FY 2018/19	(2)		(4,887,582)		(32,656,367)	
Beginning Balance for Fiscal Year		**97,583,337**	**112,478,125**	**101,910,790**	**101,910,790**	**101,910,790**
Revenue for MHSA Allocation		113,304,133	122,944,077	117,925,360	31,480,900	117,925,360
Interest Revenue		1,384,739	2,780,469	1,416,724	549,940	1,416,724
Transfers from Community Services and Supports to Other MHSA Subaccounts to Cover Approved Project Expenses	(3)		(4,355,983)	(25,154,294)	(73,883)	(25,154,294)
Total Funding Available		**212,272,209**	**233,846,688**	**196,098,580**	**133,867,747**	**196,098,580**
Board and MHSA Committee Approved Projects per MHSA Plan						
Intensive Outpatient (Full Service Partnership (FSP) Programs)						
1. Children's Full Service Partnership/Wraparound		12,634,453	13,745,373	6,654,575	(525,190)	6,654,575
2. Children and Youth Behavioral Health Program of Assertive Community Treatment				1,100,000		1,100,000
3. Transitional Age Youth Full Service Partnership/Wraparound		6,057,135	5,905,778	10,684,468	(43,788)	10,684,468
4. Adult Full Service Partnership		29,683,134	30,430,678	21,592,093	735,442	21,592,093
5. Adult Program of Assertive Community Treatment		321,784	814,306	8,631,926		8,631,926
6. Transitional Age Youth Program of Assertive Community Treatment				896,092	35,143	896,092
7. Assisted Outpatient Treatment		744,761	692,498	5,015,841	40,805	5,015,841
8. Mental Health Court-Probation Services		-		921,000	-	921,000
9. Older Adult Full Service Partnership		2,716,050	1,845,645	2,683,249	(27,630)	2,683,249
10. Older Adult Program of Assertive Community Treatment		-		521,632		521,632
11. FSP Portion of Non-Admin Programs under Other Programs		-	-	16,042,428		16,042,428
Total Intensive Outpatient (FSP Programs)		**52,157,317**	**53,434,278**	**74,743,304**	**214,782**	**74,743,304**
Non-FSP Navigation /Access and Linkage to Treatment						
1. BHS Outreach & Engagement (Adult)		514,325	480,871	1,227,973	28,220	1,227,973
2. Correctional Health Services: Jail to Community Re-Entry				3,200,000	-	3,200,000
3. The Courtyard (Outreach)		146,356	175,979	475,000	-	475,000
Crisis						
4. Children's Crisis Assessment Team (CAT)		1,019,320	932,950	1,265,613	58,690	1,265,613
5. Adult/Adult Transitional Age Youth (TAY) Crisis Assessment Team/Psychiatric Evaluation and Response Team (CAT/PERT)		3,244,823	3,371,144	4,451,183	150,248	4,451,183
6. Crisis Stabilization Units			1,020	4,250,000	(1,020)	4,250,000
7. Children's In-Home Crisis Stabilization		306,793	288,206	325,644	(881)	325,644
8. Adult and Transitional Age Youth In-Home Crisis Stabilization				1,275,000	-	1,275,000
9. Children's Crisis Residential		802,825	822,155	1,001,474	(116,557)	1,001,474
10. Transitional Age Youth Crisis Residential				74,568		74,568
11. Adult Crisis Residential		1,062,366	1,478,574	3,000,983	(38,771)	3,000,983
Outpatient Treatment						
12. Youth Core Services		447,773	(138,403)	2,300,000	(118,679)	2,300,000
13. OC Children w/Co-Occurring Mental Health Disorder (Chronic Acute Severe Physical Illness, Special Needs or Eating Disorders)		436,950		1,250,000	(96,483)	1,250,000
14. Integrated Community Services		1,667,051	1,435,019	1,848,000	30,886	1,848,000
15. Recovery Centers/Clinic Recovery Services / Open Access		6,806,480	6,160,354	8,975,360	56,318	8,975,360
16. Older Adult Services (Recovery)		1,278,013	1,339,829	1,568,047	98,894	1,568,047
Supportive Housing						-
17. Housing/Year-Round Emergency Shelter		111,116	132,619	957,026	(29,913)	957,026
18. Bridge Housing for the Homeless		5,000,000	35,000,000	1,000,000		1,000,000
19. Housing			65,841	120,644	11,868	120,644
Residential Treatment						
20. Adolescent Dual Diagnosis Residential Treatment (Children's Co-Occurring Mental Health and Substance Abuse Disorders Residential Treatment)		204,710	354,628	427,500	(29,368)	427,500
21. Adult Dual Diagnosis Residential Treatment (Adult Co-Occurring Mental Health And Substance Abuse Disorders Residential Treatment)			264,025	50,000		50,000
Recovery and Supportive Services						
12. Mentoring for Children and Youth		413,985	489,628	500,000	(2,891)	500,000
13. Peer Mentoring (Adult/Older Adult)		934,528	1,258,483	4,249,888	(38,685)	4,249,888
14. Wellness Centers		2,565,552	2,789,019	2,766,198	3,782	2,766,198
15. Supportive Employment		980,114	973,059	1,097,010	7,915	1,097,010
16. Transportation				1,000,000		1,000,000
Other MHSA Eligible Projects			4,228,956		1,863	-
Total Non-FSP Programs		**27,943,080**	**61,903,956**	**48,657,111**	**(24,564)**	**48,657,111**
Program Related County Costs		14,806,105	16,597,664	22,212,075	(157,341)	22,212,075
Total Program and Administrative Costs	(7)	**94,906,502**	**131,935,898**	**145,612,490**	**32,877**	**145,612,490**
Projected Carryover of Available Funds		**117,365,707**	**101,910,790**	**50,486,090**	**133,834,870**	**50,486,090**
Pending Obligations/Adjustments:	(4)					
Purchase of Site for Co-Located Behavioral Health Services		-	(7,723,934)	(7,723,934)		(7,723,934)
Remaining Allocation for Housing (Original $70.5M)		-	(55,000,000)	(55,000,000)		(55,000,000)
ADJUSTED Projected Carryover of Available Funds Less Known Obligations		**117,365,707**	**39,186,856**	**(12,237,844)**		**(12,237,844)**
Estimated New Revenue for FY 2019-20		**-**	**-**	**121,939,586**		**121,939,586**
Projected Available Funds for FY 2019-20				**109,701,742**		**109,701,742**

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19 (As of August 2018)
Prevention and Early Intervention (PEI)

Purpose: To report on the revenues and expenditures by MHSA component and identify any pending items to provide information needed for strategic planning and programming.

		FY 16/17	FY 17/18	FY 18/19		
		Actuals	Actuals	Budget	Actuals	Projections
Carryover of Funds from Prior Fiscal Year	(1)	**35,453,774**	**34,106,806**	**27,985,564**	**32,808,649**	**27,985,564**
Adjustment for Prior Year Expenditures paid in FY 2018/19	(2)		(6,865,647)	-	(4,823,085)	
Beginning Balance for Fiscal Year		**35,453,774**	**27,241,159**	**27,985,564**	**27,985,564**	**27,985,564**
Revenue for MHSA Allocation		28,326,033	30,736,019	29,481,340	7,870,225	29,481,340
Interest Revenue		497,692	692,779	509,460	137,485	509,460
Total Funding Available		**64,277,499**	**58,669,957**	**57,976,364**	**35,993,274**	**57,976,364**
Board and MHSA Committee Approved Projects MHSA Plan						
Prevention						
1. School Readiness and Connect the Tots (Combined)		1,595,446	1,666,745	2,200,000	69,251	2,200,000
2. School Based Behavioral Health Intervention and Support		440,000	1,794,994	1,808,589	(75,241)	1,808,589
3. School Based Stress Management Services		154,999	148,860	155,000	(40,605)	155,000
4. Violence Prevention Education		1,129,470	985,619	1,105,651	(88,933)	1,105,651
5. Gang Prevention Services		68,313	240,041	253,100	(15,049)	253,100
6. Training, Assessment and Coordination Services		143,665	17,600	508,610	-	508,610
7. Mental Health Community Educational Events		305,601	214,333	214,333	(14,274)	214,333
8. Statewide Projects		900,000	900,000	900,000	-	900,000
Navigation/Access and Linkage to Treatment						
9. Information and Referral / OC Links		745,325	964,569	1,000,000	83,121	1,000,000
10. Behavioral Health Services Outreach and Engagement Services		1,035,195	935,925	1,300,000	48,127	1,300,000
11. Outreach and Engagement Collaborative		2,618,227	2,680,544	2,819,044	(15,184)	2,819,044
Crisis						
12. Crisis Prevention Hotline		239,933	430,418	392,533	7,838	392,533
Outpatient Treatment						
13.4 OC Parent Wellness (OC Maternal and Family Wellness)		1,910,953	1,656,481	2,113,072	82,215	2,113,072
14. Stress Free Families		470,101	555,913	534,693	33,614	534,693
15. 1st Onset of Psychiatric Illness		1,414,835	1,431,728	1,500,000	67,264	1,500,000
16. Early Intervention Services for Older Adults		1,406,881	1,469,855	1,469,500		1,469,500
17. School Based Mental Health Services (Combined)		2,142,292	2,154,976	2,915,236	141,652	2,915,236
18. School Based Behavioral Health Intervention and Support-Early Intervention Services		1,703,956	437,453	440,000		440,000
19. Survivor Support Services		286,799	271,901	343,693	(17,069)	343,693
20. Community Counseling and Supportive Services		1,681,686	1,880,480	2,186,136	89,723	2,186,136
21. OC ACCEPT		478,383	520,853	490,000	31,441	490,000
22. OC4VETS		1,179,053	792,565	1,295,957	21,470	1,295,957
23. College Veterans Programs		79,724	84,383	400,000		400,000
Recovery and Supportive Services						
24. Parent Education Services		466,120	570,475	1,066,000	(5,929)	1,066,000
25. Family Support Services		688,611	479,509	282,000	(4,179)	282,000
26. Children's Support and Parenting Program		1,398,962	1,386,093	1,800,000	79,825	1,800,000
27. WarmLine		450,658	462,342	536,566		536,566
28. Training in Physical Fitness and Nutrition		9,045	1,735	15,000	-	15,000
Other Eligible Programs					4,040	
Total Prevention and Early Intervention Programs		**25,144,233**	**25,136,390**	**30,044,713**	**483,118**	**30,044,713**
Program Related County Costs		5,026,460	5,548,003	5,408,048	117,397	5,408,048
Total Program and Administrative Costs	(7)	**30,170,693**	**30,684,393**	**35,452,761**	**600,515**	**35,452,761**
Projected Carryover of Available Funds		**34,106,806**	**27,985,564**	**22,523,603**	**35,392,759**	**22,523,603**
Pending Obligations/Adjustments:	(5)					
Release liability recorded in previous fiscal year			243,837	243,837		243,837
Reclassify portion of PEI amount moved to Prudent Reserve per State			11,343,034	11,343,034		11,343,034
ADJUSTED Projected Carryover of Available Funds Less Known Obligations		**34,106,806**	**39,572,435**	**34,110,474**	**35,392,759**	**34,110,474**
Estimated New Revenue for FY 2019-20		**-**		**30,640,176**		**30,640,176**
Projected Available Funds for FY 2019-20				**64,750,650**		**64,750,650**

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19 (As of August 2018)
Innovation (INN)

Purpose: To report on the revenues and expenditures by MHSA component and identify any pending items to provide information needed for strategic planning and programming.

		FY 16/17	FY 17/18	FY 18/19		
		Actuals	Actuals	Budget	Actuals	Projections
Carryover of Funds from Prior Fiscal Year	(1)	**22,574,691**	**28,241,626**	**29,913,516**	**33,383,653**	**29,913,516**
Adjustment for Prior Year Expenditures paid in FY 2018/19	(2)		(1,316,630)		(3,470,137)	
Beginning Balance for Fiscal Year		**22,574,691**	**26,924,996**	**29,913,516**	**29,913,516**	**29,913,516**
Revenue for MHSA Allocation		7,454,219	8,088,426	7,758,247	2,071,112	7,758,247
Interest Revenue		202,985	172,857	207,740	36,180	207,740
Total Funding Available		**30,231,895**	**35,186,279**	**37,879,503**	**32,020,808**	**37,879,503**
Board and MHSA Committee Approved Projects per MHSA Plan						
Prevention						
1. Religious Leaders Behavioral Health Training Services		310,975	265,597	259,450	-	259,450
Outpatient Treatment			-			
2. Strong Families-Strong Children: Behavioral Health Services for Military Families		531,308	434,322	495,904	(10,173)	495,904
Recovery and Supportive Services						
3. Continuum of Care for Veteran and Military Children and Families			1,193	961,871	-	961,871
4. Step Forward Project: On-Site Engagement in the Collaborative Courts		276,958	216,489	224,015	(112)	224,015
5. Behavioral Health Services for Independent Living			367,280	402,234	6	402,234
Special Projects						
6. Mental Health Technology Solutions			3,007,428	6,000,000	6,017,713	6,000,000
7. OC Additional Components to Tech Solutions				2,000,000	-	2,000,000
Total Innovation Programs		**1,119,241**	**4,292,309**	**10,343,474**	**6,007,434**	**10,343,474**
Program Related County Costs		871,028	980,454	1,861,825	27,460	1,861,825
Total Program and Administrative Costs	(7)	**1,990,269**	**5,272,763**	**12,205,299**	**6,034,894**	**12,205,299**
Projected Carryover of Available Funds		**28,241,626**	**29,913,516**	**25,674,204**	**25,985,914**	**25,674,204**
Estimated New Revenue for FY 2019-20		**-**		**8,136,876**		**8,136,876**
Projected Available Funds for FY 2019-20				**33,811,080**		**33,811,080**

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19 (As of August 2018)
Workforce Education and Training (WET)

Purpose: To report on the revenues and expenditures by MHSA component and identify any pending items to provide information needed for strategic planning and programming.

		FY 16/17	FY 17/18	FY 18/19		
		Actuals	Actuals	Budget	Actuals	Projections
Carryover of Funds from Prior Fiscal Year	(1)			-	-	-
Transfers from Community Services and Supports to Cover Approved Project Expenses	(2)	4,547,430	4,355,983	5,150,282	86,854	5,150,282
Total Funding Available for FY 2018-19				**5,150,282**	**86,854**	**5,150,282**
Board and MHSA Committee Approved Projects per MHSA Plan						
1. Workforce Staffing Support		508,876	1,128,221	1,120,000	66,124	1,120,000
2. Training and Technical Assistance		1,336,693	1,208,980	1,438,000	41,983	1,438,000
3. Mental Health Career Pathways Program		857,750	858,633	927,000	(23,870)	927,000
4. Residencies and Internships Program		225,533	233,560	238,381	9,347	238,381
5. Financial Incentives Programs		348,895	397,986	641,265	(19,979)	641,265
Total Workforce Education and Training Programs		**3,277,747**	**3,827,380**	**4,364,646**	**73,605**	**4,364,646**
Program Related County Costs		1,269,683	528,603	785,636	13,249	785,636
Total Program and Administrative Costs	(7)	**4,547,430**	**4,355,983**	**5,150,282**	**86,854**	**5,150,282**
Projected Available Funds for FY 2019-20		-	-	-	-	-

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19 (As of August 2018)
Capital Facilities and Technological Needs

Purpose: To report on the revenues and expenditures by MHSA component and identify any pending items to provide information needed for strategic planning and programming.

		FY 16/17	FY 17/18	FY 18/19		
		Actuals	Actuals	Budget	Actuals	Projections
Carryover of Funds from Prior Fiscal Year	(1)	**3,739,869**	**3,739,869**	**472,322**	**1,316,125**	**472,322**
Prior Period Adjustments	(2)					-
Adjust for prior period expenditures paid in FY 18/19					(843,803)	
Beginning Balance for Fiscal Year		**3,739,869**	**3,739,869**	**472,322**	**472,322**	**472,322**
Transfers from Community Services and Supports to Cover Approved Project Expenses	(2)	3,418,388	-	20,004,012	-	20,004,012
Total Funding Available for FY 2018-19		**7,158,257**	**3,739,869**	**20,476,334**	**472,322**	**20,476,334**
Board and MHSA Committee Approved Projects per MHSA Plan						
1. Co-Located Services Facility		-	-	9,000,000		9,000,000
2. Youth Core Services Building Upgrades		-	-	200,000		200,000
6. Electronic Health Record (EHR)		2,796,656	2,974,762	8,152,825	75,067	8,152,825
Total Workforce Education and Training Programs		**2,796,656**	**2,974,762**	**17,352,825**	**75,067**	**17,352,825**
Program Related County Costs		621,732	292,785	3,123,509	-	3,123,509
Total Program and Administrative Costs	(3)	**3,418,388**	**3,267,547**	**20,476,334**	**75,067**	**20,476,334**
Projected Available Funds for FY 2019-20		**3,739,869**	**472,322**	**-**	**397,255**	**-**

Mental Health Services Act (MHSA/Prop 63)
Allocation Summary for Fiscal Year 2018-19
Footnotes

NOTES:

The Mental Health Services Act, otherwise known as MHSA, is a restricted funding source received as an allocation from the State. Funds are budgeted based on programs approved by the MHSA Steering Committee and included in the mandated Three-Year MHSA Plan Update which is approved by the Orange County Board of Supervisors (BOS). Amendments to the Plan also require a formal approval process.

Allocations are determined and disbursed by the State and funds not expended within a certain time period are subject to reversion back to the State. (CSS: 76%, PEI: 19%, INN: 5%)

Effective July 1, 2018, the MHSA Fund, Fund 13Y became a CEO Controlled Fund with related fiscal responsibilities being reassigned to the CEO Budget Office.

(1) Prior period adjustments pertain to transactions for FY 2017-18 business or prior for which the cash has not been disbursed. Included in this amount are the expenditure drawdowns that occurred in the fiscal year end closing process totals $42M and interest revenue earned but not yet disbursed totaling $741K.

(2) Per the MHSA Act, once the initial funding for the WET and CFTN subaccounts has been depleted, future funding is to come from the CSS allocation. To date, WET has utilized all funding previously allocated and funds are transferred from CSS as required to cover eligible expenditures. This line item includes the full amount budgeted. For CFTN, $475K remains from the original allocation and will be expended prior to any draw downs from the CSS Account.

(3) Amounts obligated are for projects approved by the Board and are pending disbursement or eligible program expenditures. These amounts may not be used for any other purposes without Board approval.
(a) Purchase of the site for the co-located behavioral health services. This is anticipated to house services for MHSA eligible clients. The site has been purchased but due to funding restrictions, MHSA funds cannot be used until certain criteria are met. Funds are anticipated to be used in FY 2018-19.
(b) IN FY 2017-18, the Board approved use of $70.5M from CSS funds to be used for Supportive Housing of which $15M has been paid to CalHFA. The balance remaining from the Board allocation is $55M and pending eligible projects to be approved.

There are two adjustments pending that pertain to FY 2017-18 that will be completed in early 2018-19: (1) Release of an amount held in a liability account as it was anticipated to be due back to the State, however, with the approval of AB114, the funds are no longer due back and are to be returned to the PEI subaccount; (2) Adjustment needed to the amount held in the Prudent Reserve to reclassify PEI funds transferred after the State's allowed timeline.

(4) Amounts for FY 2019-20 are projections provided by the State Controller's Office and are updated as needed. The amounts are provided for planning purposes and are considered estimates.

Appendix 2: List of MHSA Programs

Orange County MHSA Program Summaries by General Service Area

* Note: *A program may be sited at multiple clinic locations and/or tailor services and intervention strategies to best meet the needs of different target populations*

Prevention (n = 13 programs)	FY 16-17 Actuals		FY 17-18 Projected		FY18-19 Estimated	
	MHSA	Total	MHSA	Total	MHSA	Total
TOTALS	**$14,749,510**	**$14,789,737**	**$17,016,549**	**$17,016,549**	**$22,766,578**	**$22,766,578**
Breakout by Program:*						
Community Events and Services (n = 2 programs)						
1. Mental Health Community Education Events (PEI)	$366,689	$371,576	$257,084	$257,084	$252,913	$252,913
2. Statewide Projects (PEI)	$1,079,910	$1,079,910	$1,079,512	$1,079,512	$1,062,000	$1,062,000
School-Related Services (n = 5 programs)						
3. School-Based Behavioral Health Intervention and Support – Prevention (PEI)	$2,044,576	$2,044,576	$2,169,092	$2,169,092	$2,134,135	$2,134,135
4. Violence Prevention Education (PEI)	$1,355,251	$1,356,843	$1,185,844	$1,185,844	$1,304,668	$1,304,668
5. School Readiness/Connect the Tots (PEI)	$1,914,374	$1,914,374	$2,066,459	$2,066,459	$2,596,000	$2,596,000
6. School-Based Stress Management Services (PEI)	$185,985	$185,985	$185,916	$185,916	$182,900	$182,900
7. Gang Prevention Services (PEI)	$81,970	$81,970	$288,864	$288,864	$298,658	$298,658
Community Training (n = 2 programs)						
8. Religious Leaders Behavioral Health Training Services (INN)	$552,947	$552,947	$589,789	$589,789	$306,151	$306,151
9. Training, Assessment and Coordination Services (PEI)	$172,384	$174,092	$337,105	$337,105	$600,160	$600,160
Navigation/Access and Linkage to Services (n = 4 programs)						
10. Information and Referral/OC LINKS (PEI)	$894,316	$894,316	$1,085,527	$1,085,527	$1,180,000	$1,180,000
11. Outreach & Engagement (CSS, PEI) [a]	$5,918,579	$5,950,619	$7,445,537	$7,445,537	$8,482,993	$8,482,993
12. Multi-Service Center Courtyard Program (CSS)	$182,529	$182,529	$325,820	$325,820	$590,000	$590,000
13. CHS Jail to Community Re-Entry (CSS)	$0	$0	$0	$0	$3,776,000	$3,776,000

[a] *See Outreach and Engagement Program description for budgets separated by PEI and CSS funds*

Crisis Services (n = 6 programs)	FY 16-17 Actuals		FY 17-18 Projected		FY18-19 Estimated	
	MHSA	Total	MHSA	Total	MHSA	Total
TOTALS	**$16,294,860**	**$20,928,437**	**$20,043,315**	**$24,040,341**	**$30,725,323**	**$35,085,018**
Breakout by Program:*						
1. Crisis Prevention Hotline (PEI)	$287,896	$300,071	$400,127	$400,127	$463,189	$463,189
2. CAT / PERT (CSS)	$8,199,403	$10,429,283	$9,116,200	$11,434,714	$10,780,313	$12,575,282
3. Crisis Stabilization Units (CSS)	-	-	-	-	$5,900,000	$5,900,000
4. Survivor Support Services (PEI)	$344,130	$344,130	$341,372	$341,372	$405,558	$405,558
5. In Home Crisis Stabilization (CSS)	$1,211,626	$1,802,330	$1,469,942	$1,865,087	$3,050,866	$3,960,693
6. Crisis Residential Programs (CSS)	$6,251,805	$8,062,623	$8,715,674	$9,999,041	$10,125,397	$11,780,296

Treatment (n = 37 programs)	FY 16-17 Actuals		FY 17-18 Projected		FY18-19 Estimated	
	MHSA	Total	MHSA	Total	MHSA	Total
TOTALS	**$85,293,626**	**$97,122,714**	**$129,288,637**	**$144,929,013**	**$120,437,781**	**$139,784,704**
Breakout by Program:*						
Early Intervention Outpatient Treatment						
General Early Intervention Treatment Subcategory						
1. Community Counseling Services & Supports (PEI)	$2,017,855	$2,017,855	$2,347,875	$2,347,875	$2,579,641	$2,579,641
2. Tech Suite (INN)	-	-	$3,540,000	$3,540,000	$7,080,000	$7,080,000
Veterans Early Intervention Outpatient Services Subcategory						
3. Veterans School Based Early Intervention (PEI)	$95,661	$95,661	$194,115	$194,115	$472,000	$472,000
4. OC4Vets (PEI)	$1,414,745	$1,419,703	$1,517,879	$1,517,879	$1,529,229	$1,529,229
5. BHS for Military Families (INN)	$944,785	$944,785	$1,002,022	$1,002,022	$585,167	$585,167
LGBTIQ Services Subcategory						
6. OC ACCEPT (PEI)	$574,011	$575,555	$633,339	$633,339	$578,200	$578,200
Early Onset of Psychiatric Illness Subcategory						
7. First Onset of Psychiatric Illness (OC CREW; PEI)	$1,697,661	$1,697,885	$1,758,013	$1,758,013	$1,770,000	$1,770,000
8. Early Intervention Services for Older Adults (PEI)	$1,688,117	$1,688,117	$1,762,603	$1,762,603	$1,734,010	$1,734,010
Family Services Subcategory						
9. OC Parent Wellness Program (PEI)	$2,292,951	$2,292,951	$2,068,154	$2,068,154	$2,493,425	$2,493,425
10. Stress Free Families (PEI)	$564,074	$565,328	$657,680	$657,680	$630,938	$630,938

School-Based Outpatient Services Subcategory						
11. School-Based Behavioral Health Intervention and Supports – Early Intervention Services (PEI)	$527,956	$527,956	$524,860	$524,860	$519,200	$519,200
12. School-Based Mental Health Services (PEI)	$2,570,536	$2,570,536	$2,745,537	$2,745,537	$3,439,979	$3,439,979
Clinic-Based Outpatient Mental Health						
13. Older Adults Services (CSS)	$1,610,840	$2,372,635	$1,641,590	$2,377,244	$1,968,399	$2,530,096
Integrated Outpatient Care						
14. CYBH Co-Occurring Medical and Mental Health Clinic (CSS)	$1,035,396	$1,581,010	$1,184,800	$1,992,912	$2,950,000	$4,032,453
15. Integrated Community Services (CSS)	$1,975,121	$2,009,798	$2,064,593	$2,072,467	$2,180,640	$2,180,640
Intensive Outpatient						
16. Full Service Partnerships (CSS)	$39,018,686	$44,123,104	$50,579,792	$58,025,376	$55,023,667	$64,738,516
17. Programs of Assertive Community Treatment (CSS)	$10,098,616	$12,449,600	$10,384,928	$13,174,307	$13,156,587	$15,173,795
18. Youth Core Services (CSS)	$530,520	$1,374,328	$798,598	$1,484,004	$2,714,000	$5,261,480
Outpatient Recovery						
19. Recovery Open Access/ Recovery Clinics and Centers (CSS)	$9,329,256	$11,904,684	$8,257,185	$11,260,084	$10,807,067	$14,158,309
Residential Treatment						
20. TAY Social Rehabilitation Program	*TAY SRP budget combined with TAY Crisis Residential Program budget in Crisis Services*					
21. Co-Occurring Mental Health & Substance Use Disorders Residential Treatment (CSS)	$242,541	$312,139	$365,031	$510,556	$1,094,450	$1,166,444
Recovery and Supportive Services						
Peer Support Subcategory						
22. Warmline (PEI)	$540,745	$540,745	$556,265	$556,265	$633,148	$633,148
23. Step Forward: On-Site Engagement in the Collaborative Courts (INN)	$492,537	$492,537	$499,920	$499,920	$264,338	$264,338
24. Peer Mentoring (CSS)	$1,107,228	$1,107,228	$2,102,887	$2,102,887	$5,014,868	$5,014,868
25. Behavioral Health Services for Independent Living (INN)	0	0	$787,810	$787,810	$474,636	$474,636

26. Wellness Centers (CSS)	$3,415,355	$3,476,184	$3,974,938	$3,986,142	$3,840,134	$3,840,134
Family Support Subcategory						
27. Parent Education Services (PEI)	$559,297	$559,297	$707,691	$707,691	$1,257,880	$1,257,880
28. Family Support Services (PEI)	$826,265	$826,265	$265,535	$265,535	$332,760	$332,760
29. Children's Support and Parenting Program (PEI)	$1,678,614	$1,678,614	$1,988,708	$1,988,708	$2,124,000	$2,124,000
30. Mentoring for Children and Youth (CSS)	$490,490	$497,633	$589,878	$589,878	$590,000	$590,000
Veterans Support Subcategory						
31. Continuum of Care for Veteran & Military Children and Families (INN)	0	0	0	0	$1,135,008	$1,135,008
General Support Subcategory						
32. Supported Employment (CSS)	$1,450,637	$1,452,133	$1,599,480	$1,608,219	$1,618,089	$1,618,089
33. Training in Physical Fitness and Nutrition (PEI)	$10,853	$10,853	$6,579	$6,579	$17,700	$17,700
34. Transportation (CSS)	0	0	$88,860	$88,860	$1,180,000	$1,180,000
Supportive Housing Subcategory						
35. Year-Round Emergency Shelter (CSS)	0	0	$142,176	$142,176	$1,613,272	$1,613,272
36. Bridge Housing for the Homeless (CSS)	0	0	0	0	$2,360,000	$2,360,000
37. MHSA Special Needs Housing Program (CSS)	$6,270,223	$6,270,223	$36,366,923	$36,366,923	$569,441	$569,441
Treatment Program To be Discontinued from MHSA funds in FY 2018-19						
Mental Health Collaborative Court – Probation Services (CSS)	*$947,840*	*$947,840*	*$931,253*	*$931,253*	*$1,086,780*	*$1,086,780*
OC's Additional Component to the Technology Solutions Project (INN) *Note: Project proposal will not be pursued in FY 2018-19; will be pursued in later FY*	*0*	*0*	*0*	*0*	*$2,360,000*	*$2,360,000*

System Support (n = 7 programs)	FY 16-17 Actuals MHSA	FY 16-17 Actuals Total	FY 17-18 Projected MHSA	FY 17-18 Projected Total	FY18-19 Estimated MHSA	FY18-19 Estimated Total
TOTALS	**$7,965,819**	**$7,971,022**	**$10,420,406**	**$10,420,406**	**$25,626,617**	**$25,626,617**
Breakout by Program:*						
Workforce Education and Training (n = 5 programs)						
1. Workforce Staffing Support	$705,997	$705,997	$1,481,650	$1,481,650	$1,321,600	$1,321,600
2. Training and Technical Assistance	$1,854,479	$1,855,829	$1,712,190	$1,712,190	$1,696,840	$1,696,840
3. Mental Health Career Pathways	$1,190,013	$1,190,013	$1,249,202	$1,249,202	$1,093,860	$1,093,860
4. Residency and Internship Programs	$312,896	$312,896	$316,907	$316,907	$281,290	$281,290
5. Financial Incentive Programs	$484,045	$487,898	$551,477	$551,477	$756,693	$756,693
Capital Facilities and Technological Needs (n = 2 programs)						
6. Capital Facilities	0	0	0	0	$10,856,000	$10,856,000
7. Technological Needs	$3,418,389	$3,418,389	$5,108,980	$5,108,980	$9,620,334	$9,620,334

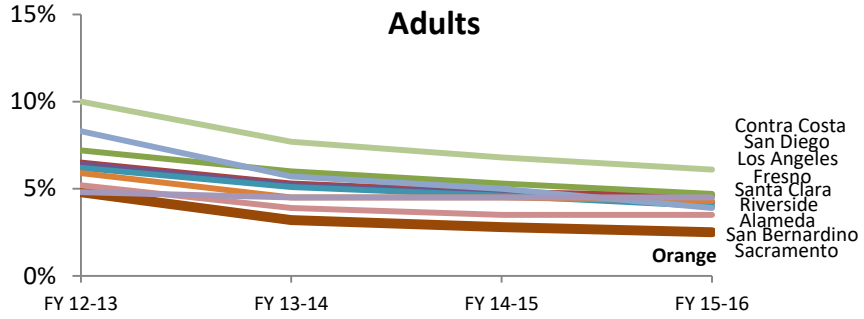
Appendix 3 – Key Indicators for Orange County

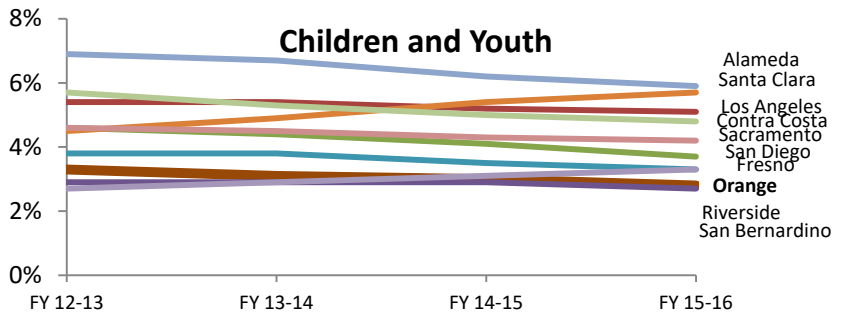
Key Indicator 1 Penetration Rates: the total number of individuals (all adults or all youth) who received at least 1 specialty mental health service in the fiscal year divided by the total number of Medi-Cal recipients (all adults or all youth) for that fiscal year.

Orange County has some of the **lowest penetration rates** compared to the other nine most populous counties. Factors that affect overall penetration rates include the expansion of Medi-Cal eligibility for low income childless adults in 2014 and also the inclusion of coverage to undocumented children in May 2016. Another variable relates to how managed health care plans are treating mild and moderate mental health needs, which may result in decreased demand for specialty mental health services.

Adults	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**4.8%**	**3.2%**	**2.8%**	**2.5%**
Los Angeles	6.5%	5.3%	4.8%	4.6%
San Diego	7.2%	6.0%	5.3%	4.7%
Riverside	6.4%	5.2%	4.7%	4.2%
San Bernardino	6.2%	5.1%	4.6%	4.0%
Santa Clara	5.9%	4.5%	4.5%	4.3%
Alameda	8.3%	5.7%	5.0%	3.9%
Sacramento	5.2%	3.9%	3.5%	3.5%
Contra Costa	10.0%	7.7%	6.8%	6.1%
Fresno	4.8%	4.5%	4.5%	4.5%

Children & Youth	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**3.3%**	**3.1%**	**3.0%**	**2.8%**
Los Angeles	5.4%	5.4%	5.2%	5.1%
San Diego	4.6%	4.4%	4.1%	3.7%
Riverside	2.9%	2.9%	2.9%	2.7%
San Bernardino	3.8%	3.8%	3.5%	3.3%
Santa Clara	4.5%	4.9%	5.4%	5.7%
Alameda	6.9%	6.7%	6.2%	5.9%
Sacramento	4.6%	4.5%	4.3%	4.2%
Contra Costa	5.7%	5.3%	5.0%	4.8%
Fresno	2.7%	2.9%	3.1%	3.3%



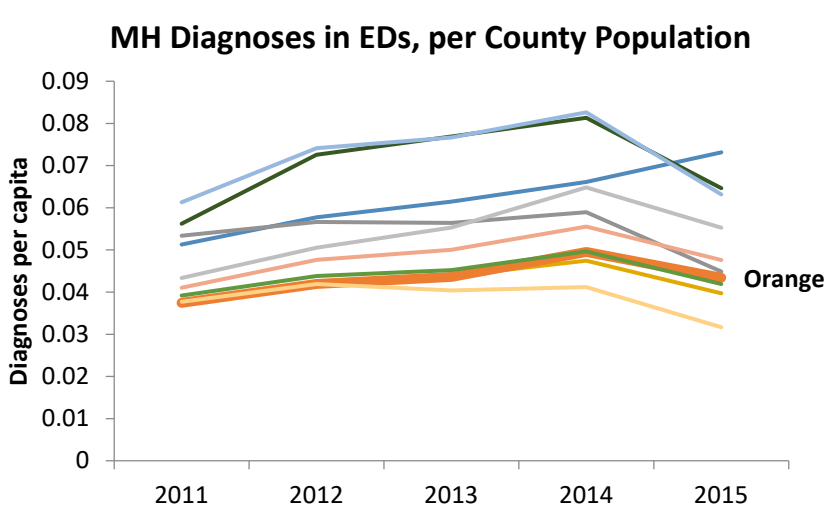


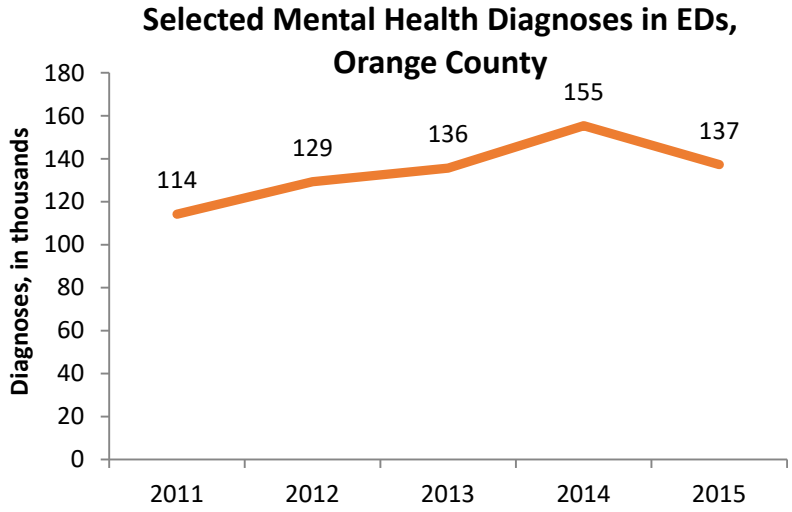
Key Indicator 2 Hospital Emergency Departments and Mental Health: Using county-level data from the California Office of Statewide Health Planning and Development (OSHPD), the graphs below show the number of emergency department visits and the associated diagnoses (primary and secondary diagnoses) for mood and personality disorders, schizophrenia and psychotic disorders, suicidal ideation, and anxiety disorders.

The graph on the left shows that Orange County had one of the lowest rates of mental health diagnoses in emergency departments – accounting for population growth - but the county's rate increased relative to other counties' rates.

The graph on the right shows the number of diagnoses in Orange County for the selected mental health conditions. From 2011 to 2015 Orange County saw a **20% increase**. Of the ten most populous counties only Contra Costa and San Diego had higher growth.

Note: These data do not include alcohol and other drug related diagnoses.

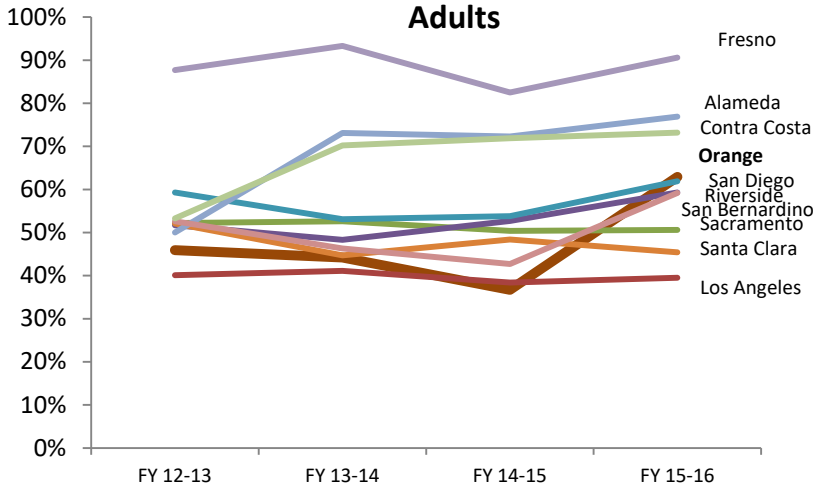


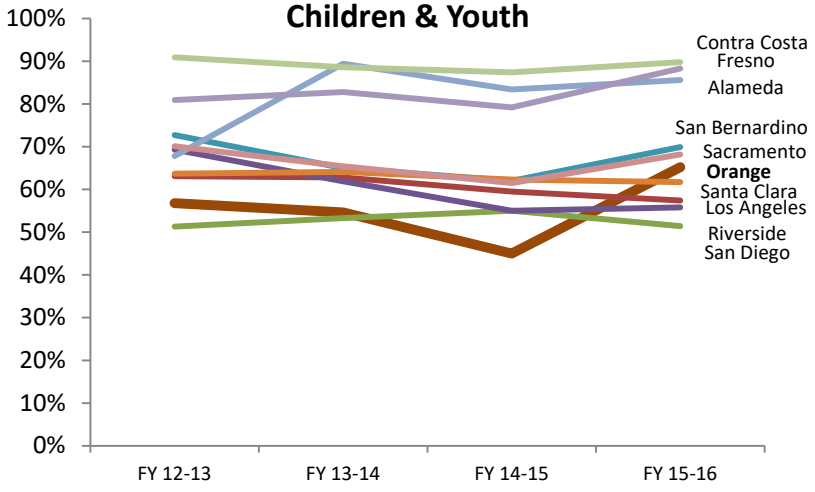


Key Indicator 3 Percent of Psychiatric Inpatient Discharges with Step Down Services within 7 days of Discharge: The graphs below show the adult population (on the left) and the children and youth population (on the right) and the proportion of individuals who receive step down services post-discharge. For both populations, Orange County's most recent data point is a significant increase. This metric, like many presented in this appendix, are claims-based. An accurate percent of inpatient discharges with step down relies on accurate claims documentation.

Adults	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**45.9%**	**44.2%**	**36.7%**	**62.9%**
Los Angeles	40.1%	41.1%	38.4%	39.5%
San Diego	52.2%	52.6%	50.4%	50.6%
Riverside	51.7%	48.3%	52.7%	59.3%
San Bernardino	59.3%	53.1%	53.8%	61.9%
Santa Clara	52.1%	44.7%	48.4%	45.4%
Alameda	50.0%	73.1%	72.3%	76.9%
Sacramento	52.6%	46.3%	42.7%	59.2%
Contra Costa	53.3%	70.2%	71.9%	73.2%
Fresno	87.7%	93.3%	82.5%	90.6%

Children and Youth	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**56.8%**	**54.6%**	**45.0%**	**65.2%**
Los Angeles	63.1%	62.8%	59.5%	57.4%
San Diego	51.3%	53.3%	55.0%	51.4%
Riverside	69.3%	61.9%	55.0%	55.8%
San Bernardino	72.7%	65.0%	62.0%	69.9%
Santa Clara	63.7%	64.1%	62.3%	61.7%
Alameda	67.8%	89.4%	83.4%	85.6%
Sacramento	70.1%	65.4%	61.5%	68.2%
Contra Costa	90.9%	88.6%	87.4%	89.8%
Fresno	80.9%	82.8%	79.2%	88.3%

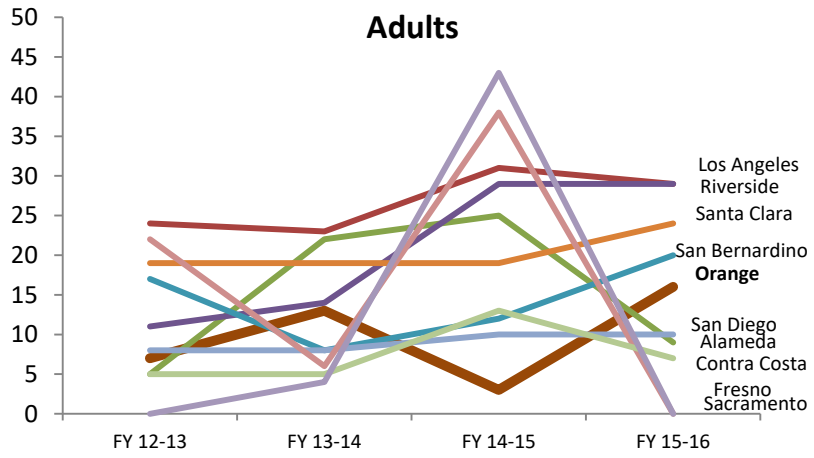


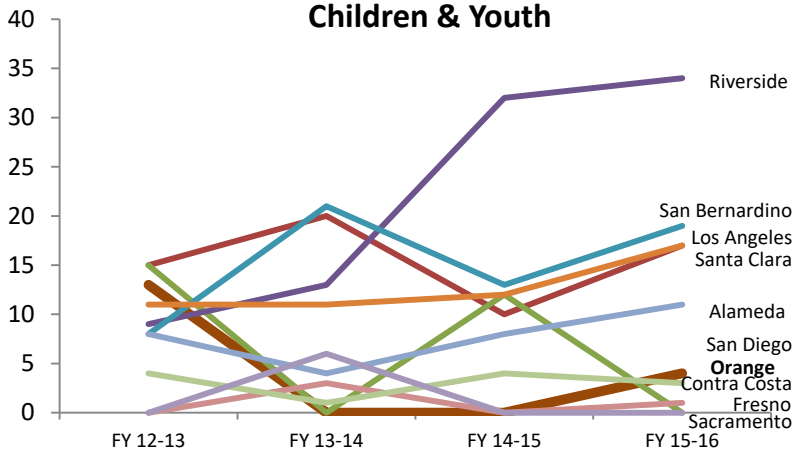


Key Indicator 4 Hospital Psychiatric Inpatient Admin Days show the duration that individuals wait to transfer to another, lower-acuity setting. This measure could reflect the capacity and/or availibility of lower-acuity settings. This figure could be an underrepresentaiton because hospitals must document certain processes in order to receive payment for admin days. Also, for dual-eligile individuals, the County may not always pay for admin days.[1]

Adults	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**7**	**13**	**3**	**16**
Los Angeles	24	23	31	29
San Diego	5	22	25	9
Riverside	11	14	29	29
San Bernardino	17	8	12	20
Santa Clara	19	19	19	24
Alameda	8	8	10	10
Sacramento	22	6	38	0
Contra Costa	5	5	13	7
Fresno	0	4	43	0

Children & Youth	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**13**	**0**	**0**	**4**
Los Angeles	15	20	10	17
San Diego	15	0	12	0
Riverside	9	13	32	34
San Bernardino	8	21	13	19
Santa Clara	11	11	12	17
Alameda	8	4	8	11
Sacramento	0	3	0	1
Contra Costa	4	1	4	3
Fresno	0	6	0	0



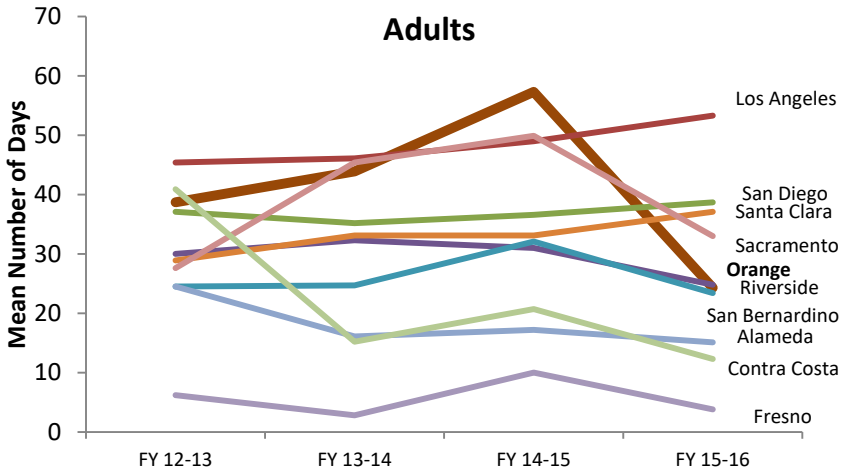


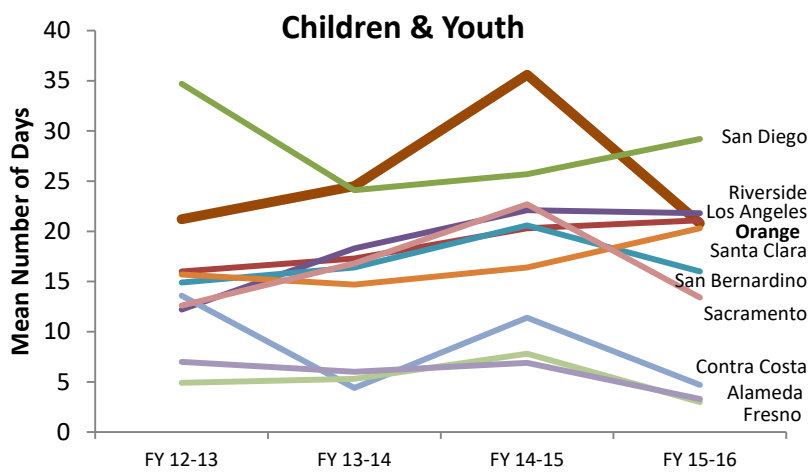
[1] Defined as patients and units associated with SDMC2 (Short Doyle/Medi-Cal) claims that were billed with revenue code 0101. During a hospital stay, the beneficiary has previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of 5 appropriate, non-acute treatment facilities per week subject to the requirements stated in CCR Title 9, Section 1820.220. (http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf)

Key Indicator 5 Mean Number of Days Between Inpatient and Step Down Service conveys the speed at which individuals receive care, going from an inpatient setting to a step down program. An increasing trend could reflect inadequate step down service capacity. Note: the step down service must be billable, which may not consider other types of services. Furthermore, step down services may not capture all outpatient services such as community-based organizations.

Adults	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**39**	**44**	**57**	**24**
Los Angeles	45	46	49	53
San Diego	37	35	37	39
Riverside	30	32	31	25
San Bernardino	25	25	32	23
Santa Clara	29	33	33	37
Alameda	25	16	17	15
Sacramento	28	45	50	33
Contra Costa	41	15	21	12
Fresno	6	3	10	4

Children & Youth	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**21.2**	**24.5**	**35.6**	**20.8**
Los Angeles	16.0	17.3	20.3	21.1
San Diego	34.7	24.1	25.7	29.2
Riverside	12.2	18.3	22.1	21.8
San Bernardino	14.9	16.4	20.6	16.0
Santa Clara	15.7	14.7	16.4	20.3
Alameda	13.6	4.4	11.4	4.7
Sacramento	12.6	16.8	22.7	13.4
Contra Costa	4.9	5.3	7.8	3.0
Fresno	7.0	6.0	6.9	3.3

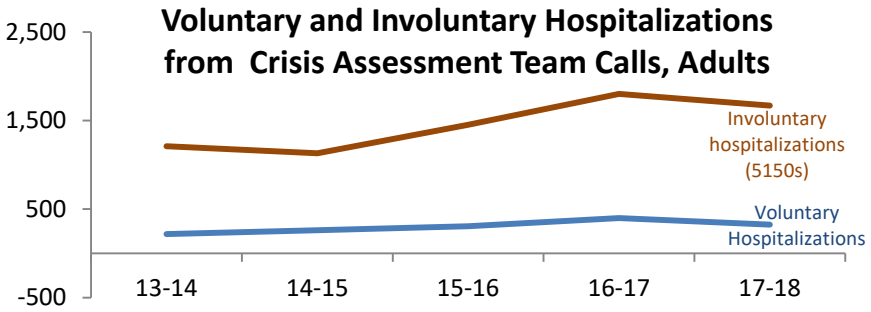


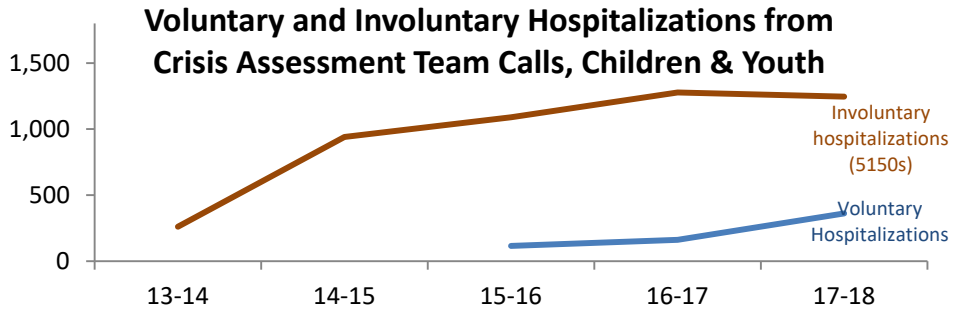


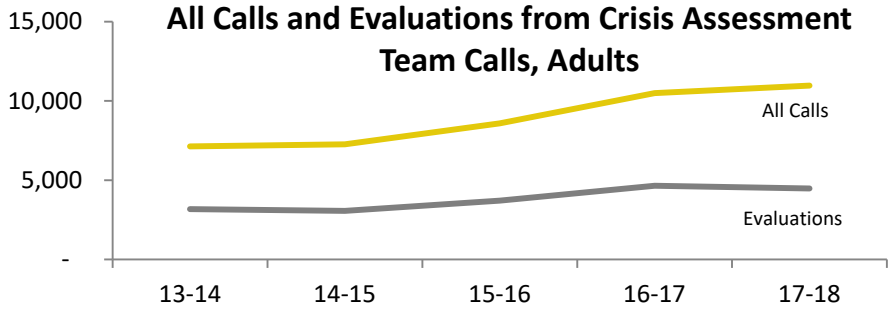
Key Indicator 6 Trend for Crisis Assessment Team Calls including "5150s" (Orange county only) shows all calls, evaluations, involuntary hospitalizations and voluntary hospitalizations from Adult and Older Adult Behavioral Health (AOABH) and Children and Youth Behavioral Health (CYBH) programs.

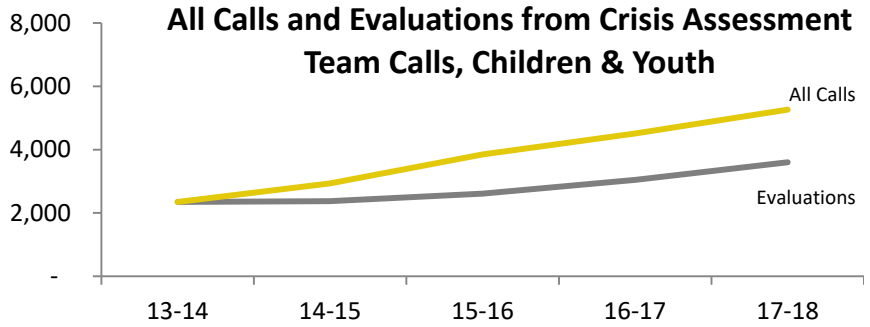
Adults	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Voluntary Hospitalizations	218	262	307	398	325
Involuntary hospitalizations (5150s)	1,210	1,131	1,453	1,801	1,669
Evaluations	3,173	3,060	3,704	4,647	4,473
All Calls[2]	7,131	7,264	8,585	10,496	10,964

Children & Youth	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Voluntary Hospitalizations	-	-	115	161	361
Involuntary Hospitalizations (5150s)	261	940	1,089	1,277	1,246
Evaluations	2,346	2,375	2,612	3,044	3,602
All Calls	2,346	2,934	3,849	4,511	5,262





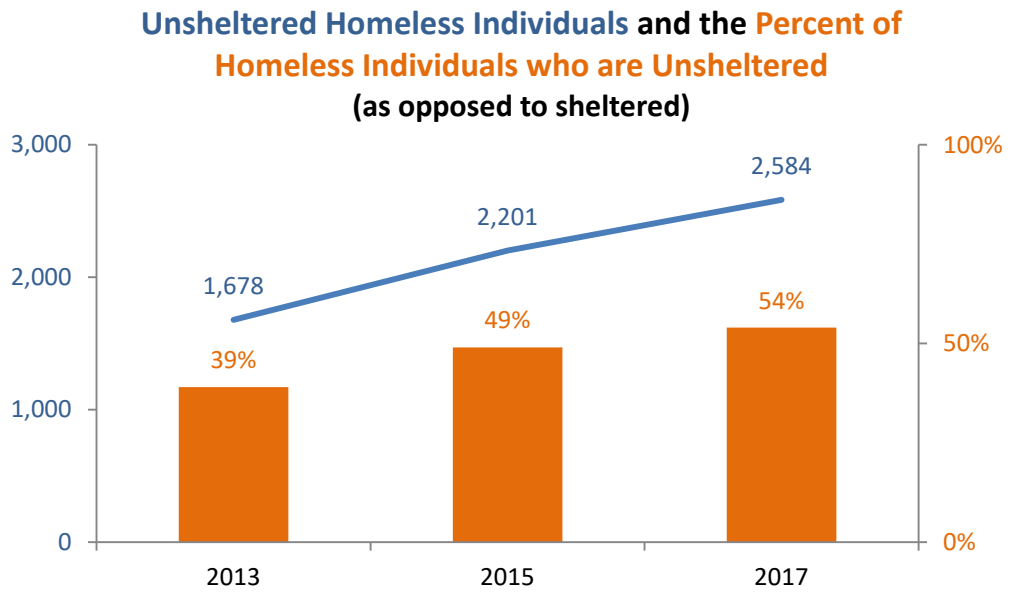




[2] All Calls includes canceled evaluations and information-only calls, which request general consultation or information but do not request crisis evaluation.

Key Indicator 7 Unsheltered Homeless Individuals

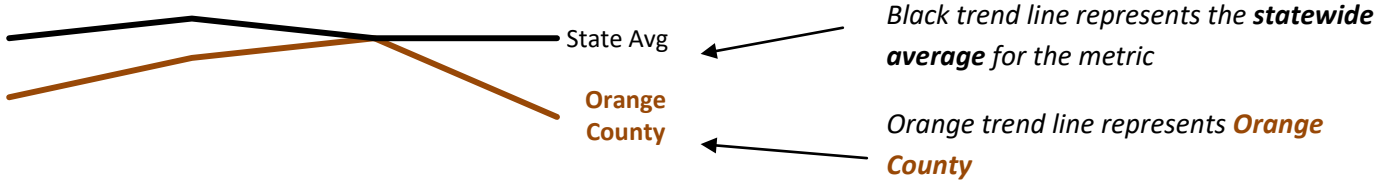
Orange County's point-in-time homeless count report shows approximately 12% of homeless adults self-identified as having a Serious Mental Illness. The percent of homeless individuals who are unsheltered has increased over time, from 39% to 54%.



Appendix 4: Additional Indicators for Orange County

Orange County and Statewide Four-Year Trends

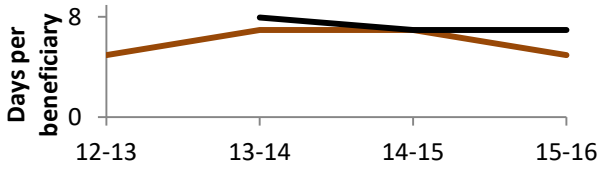
How to read this dashboard

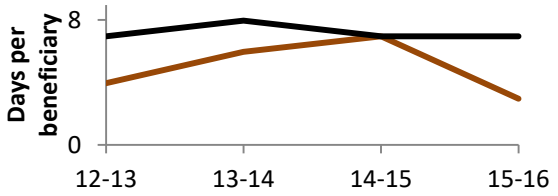


Adult Trends | **Children & Youth Trends**

Hospital inpatient days reflect the number of days individuals recieve inpatient care in a hospital divided by the total number of beneficiaries. This value portrays the level of service acuity. Two interpretations of an increasing trend are that more individuals are needing a higher level of care or that the delivery system for outpatient care is not accessible enough.

Hospital psychiatric inpatient days per unique beneficiary[3]



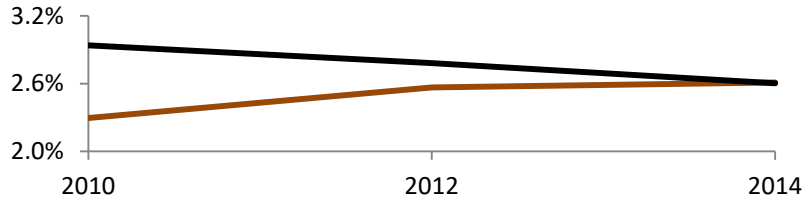


Note: the following metrics are not available separately for children and adults.

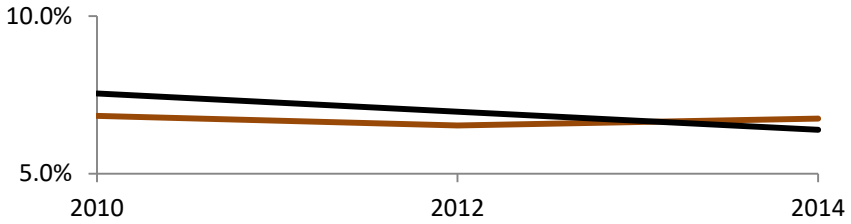
[3] Defined as patients and units associated with SDMC2 (Short Doyle/Medi-Cal) claims that were billed with revenue code 0100. Hospital inpatient services are defined as provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital that is approved by DHCS to provide psychiatric services. (http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf)

The two metrics below reflect the capacity of the behavioral health sytem. An increasing trend could mean that the prevalence of illicit drug or alcohol use is increasing. It could also mean that fewer providers offer treatment options, or both.

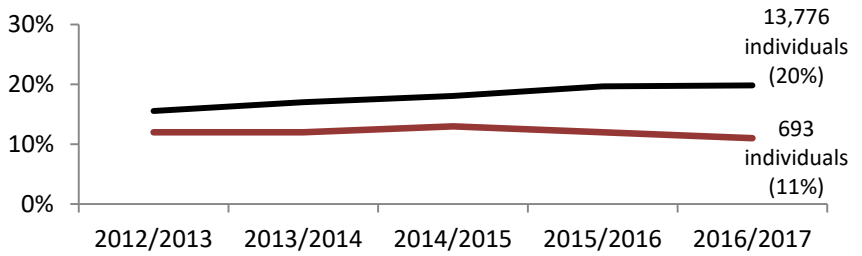
Share of Population Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year among Individuals Aged 12 or Older



Share of Population Needing But Not Receiving Treatment for Alcohol Use in the Past Year among Individuals Aged 12 or Older



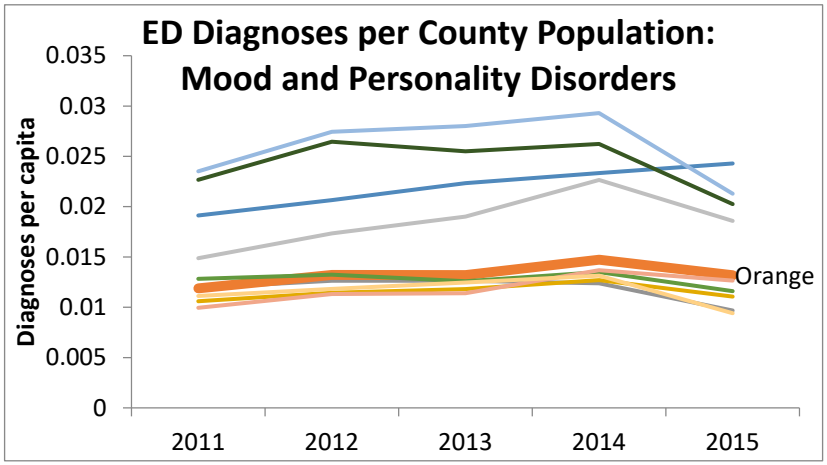
The number of incarcerated individuals receiving psychotropic medications (as a percent of average daily population)[4]

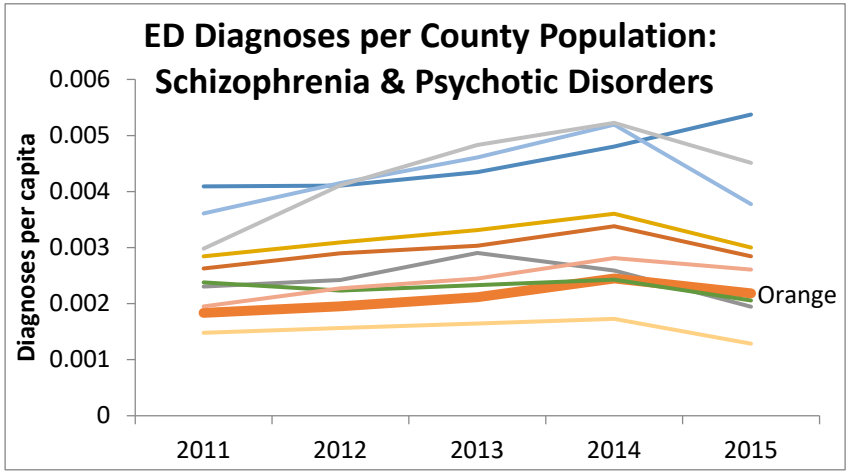


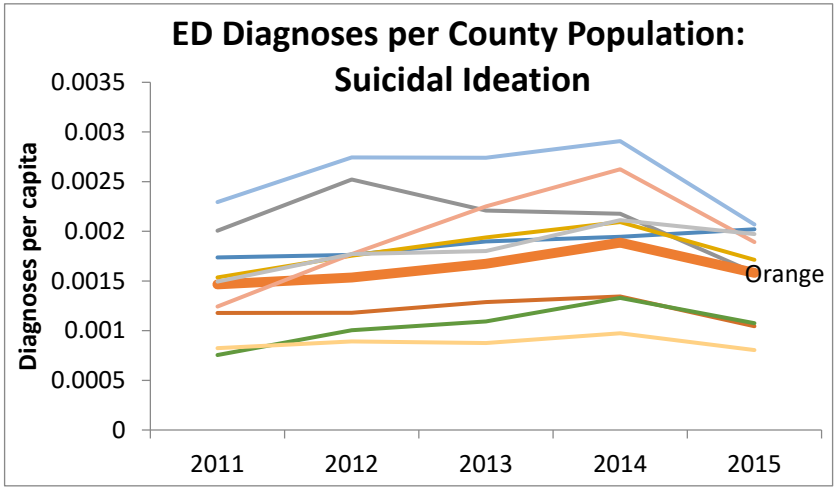
[4] The statewide average reflects 45 counties, as reflected in the data set.

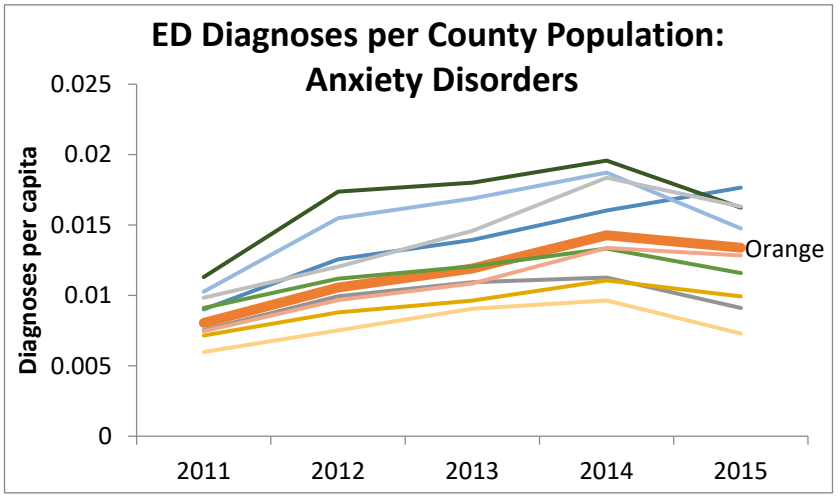
Emergency Department diagnoses – comparing Orange County to the ten most populous counties

These graphs show emergency department admissions by diagnoses, including primary and all secondary diagnoses.







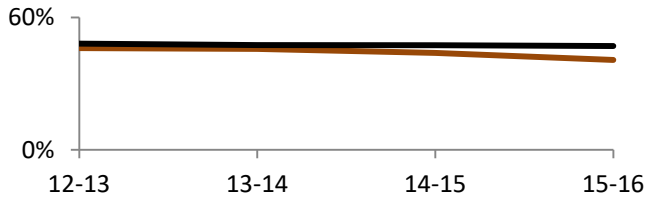


Foster Youth Data

Statewide Comparison Data

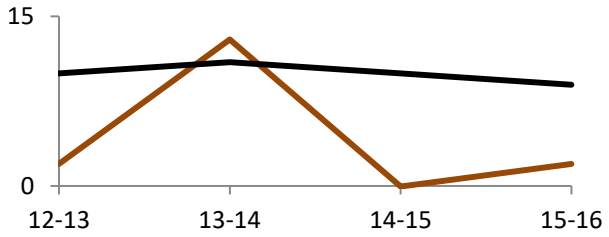
Penetration rate is the ratio of individuals who received at least one specialty mental health visit divided by the total number of Medi-Cal eligible individuals in that category (children, adults, or foster youth). This metric indicates the level of service provision as a function of delivery system capacity, but may also reveal the prevelance of mental health service needs.

Penetration rates - individuals with at least 1 specialty mental health service visit



Hospital psychiatric inpatient days reflect the number of days individuals recieve inpatient care in a hospital divided by the total number of beneficiaries. This value portrays the level of service acuity. Two interpretations of an increasing trend are that more individuals are needing a higher level of care or that the delivery system for outpatient care is not accessible enough.

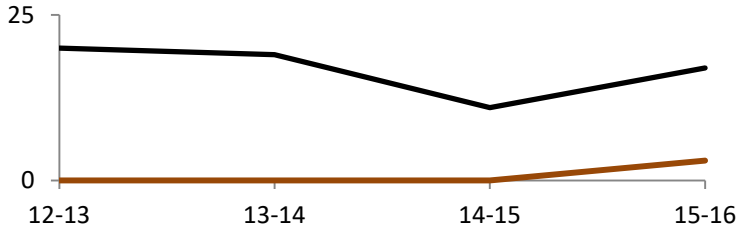
Hospital psychiatric inpatient days per unique beneficiary[5]



[5] Defined as patients and units associated with SDMC2 (Short Doyle/Medi-Cal) claims that were billed with revenue code 0100. Hospital inpatient services are defined as provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital that is approved by DHCS to provide psychiatric services. (http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf)

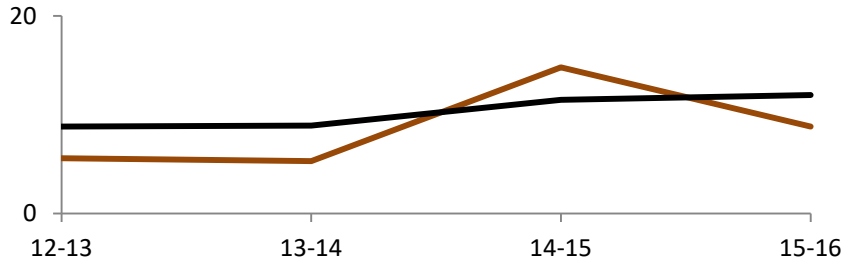
Hospital inpatient admin days show the duration that individuals wait to transfer to another, lower-acuity setting. This measure could reflect the capacity and/or availibility of lower-acuity settings.

Hospital psychiatric inpatient *admin* days per unique beneficiary[6]



The mean number of days between inpatient and step down service conveys the speed at which individuals receive care, going from an inpatient setting to a step down program. An increasing trend could reflect inadequate step down service capacity.

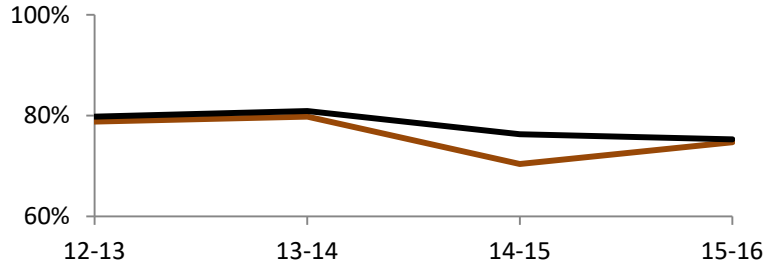
Mean number of days between inpatient discharge and step down service



[6] Defined as patients and units associated with SDMC2 (Short Doyle/Medi-Cal) claims that were billed with revenue code 0101. During a hospital stay, the beneficiary has previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of 5 appropriate, non-acute treatment facilities per week subject to the requirements stated in CCR Title 9, Section 1820.220. (http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf)

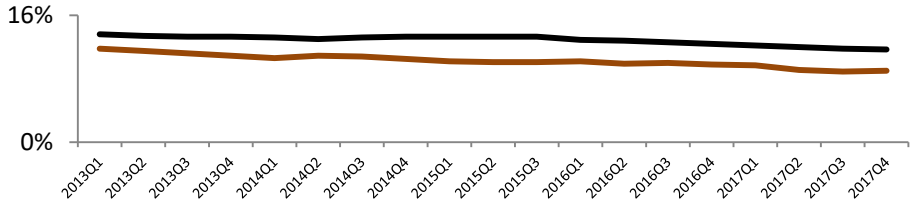
Similar to mean number of days between inpatient and step down service, the percent of discharges within 7 days between inpatient discharge and step down service reflects the system capacity of step down services and the speed with which individuals can begin access. An increasing trend could reflect worsening access to step down services.

Percent of discharges within 7 days between inpatient discharge and step down service



The metric below focuses on use of psychotropic medicationamong foster youth. The use of psychotropic medications does not directly relate to MHSA services, but provides useful data points to compare Orange County with state averages.

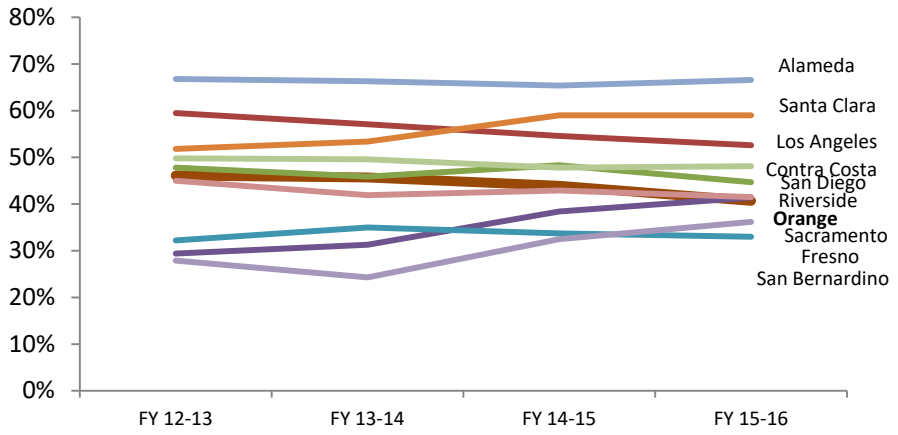
Use of psychotropic medication among youth in foster care, as a percent of foster youth



County Comparison Data- Top 10 Counties by Population

Penetration rates with at least one specialty mental health services visit, Foster Youth

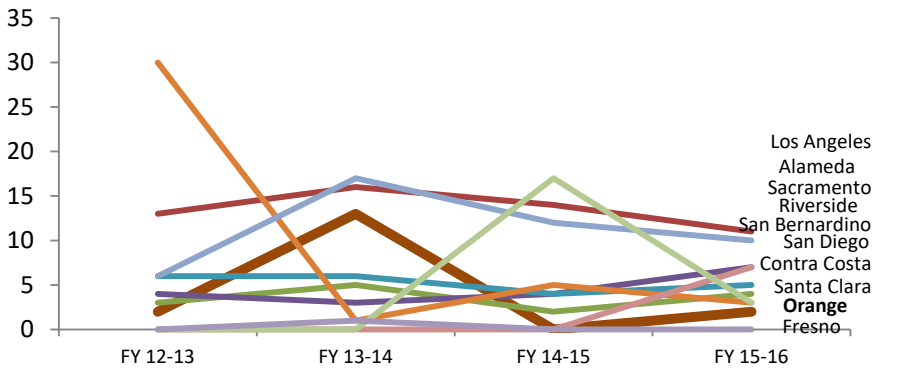
Foster	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**46.1%**	**45.7%**	**43.9%**	**40.7%**
Los Angeles	59.5%	57.1%	54.6%	52.6%
San Diego	47.8%	45.9%	48.3%	44.7%
Riverside	29.4%	31.3%	38.4%	41.4%
San Bernardino	32.2%	35.0%	33.7%	33.0%
Santa Clara	51.8%	53.4%	59.0%	59.0%
Alameda	66.8%	66.3%	65.4%	66.6%
Sacramento	45.0%	41.9%	42.9%	41.5%
Contra Costa	49.8%	49.6%	47.8%	48.1%
Fresno	27.9%	24.3%	32.5%	36.2%



County Comparison Data- Top 10 Counties by Population

Hospital inpatient days per unique beneficiary, Foster Youth

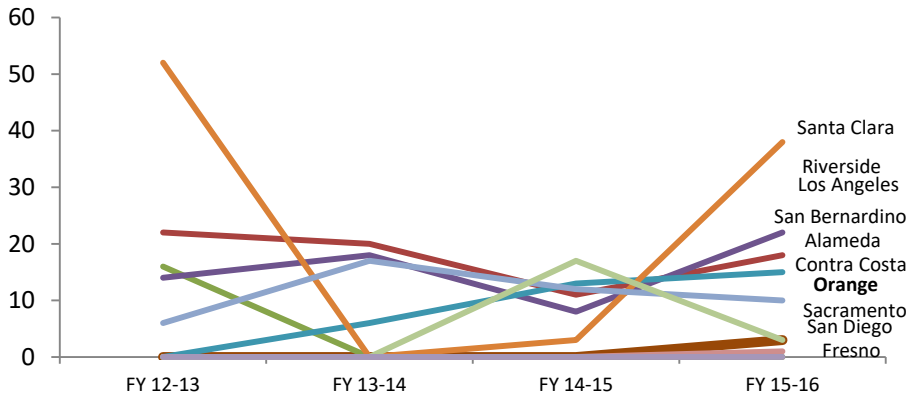
Foster	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**2**	**13**	**0**	**2**
Los Angeles	13	16	14	11
San Diego	3	5	2	4
Riverside	4	3	4	7
San Bernardino	6	6	4	5
Santa Clara	30	1	5	3
Alameda	6	17	12	10
Sacramento	0	0	0	7
Contra Costa	0	0	17	3
Fresno	0	1	0	0



County Comparison Data- Top 10 Counties by Population

Hospital inpatient admin days per unique beneficiary, Foster Youth

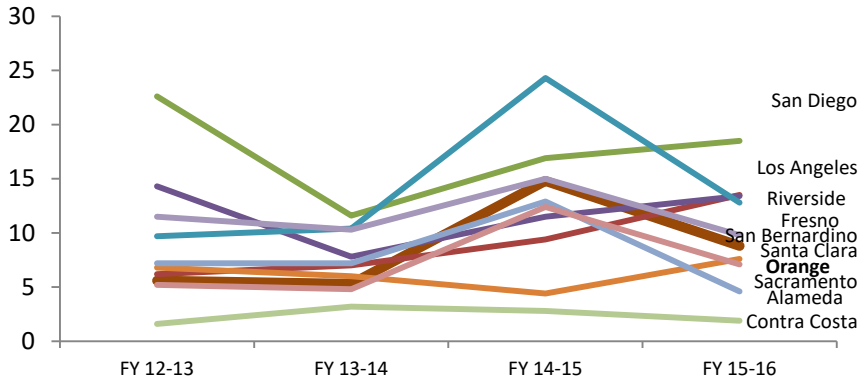
Foster	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**0**	**0**	**0**	**3**
Los Angeles	22	20	11	18
San Diego	16	0	0	0
Riverside	14	18	8	22
San Bernardino	0	6	13	15
Santa Clara	52	0	3	38
Alameda	6	17	12	10
Sacramento	0	0	0	1
Contra Costa	0	0	17	3
Fresno	0	0	0	0



County Comparison Data- Top 10 Counties by Population

Mean time between inpatient discharge and step-down service, in days, Foster Youth

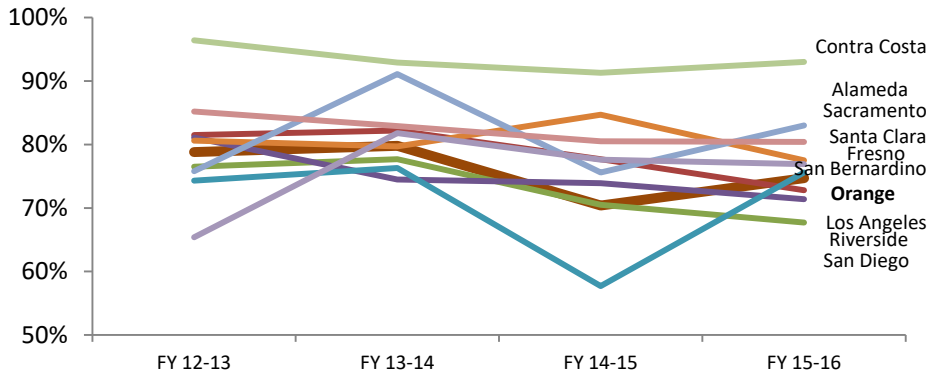
Foster	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**5.6**	**5.3**	**14.8**	**8.8**
Los Angeles	6.2	7.0	9.4	13.5
San Diego	22.6	11.6	16.9	18.5
Riverside	14.3	7.8	11.5	13.4
San Bernardino	9.7	10.4	24.3	12.8
Santa Clara	6.8	6.0	4.4	7.6
Alameda	7.2	7.2	12.9	4.6
Sacramento	5.2	4.8	12.4	7.1
Contra Costa	1.6	3.2	2.8	1.9
Fresno	11.5	10.3	15.0	9.8



County Comparison Data- Top 10 Counties by Population

Percent of discharges by time between inpatient discharge and step-down service (within 7 days), Foster Youth

Foster	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Orange	**78.8%**	**79.8%**	**70.4%**	**74.7%**
Los Angeles	81.5%	82.2%	77.7%	72.8%
San Diego	76.5%	77.7%	70.5%	67.7%
Riverside	81.1%	74.5%	73.9%	71.4%
San Bernardino	74.3%	76.3%	57.7%	75.6%
Santa Clara	80.6%	79.7%	84.7%	77.5%
Alameda	75.8%	91.1%	75.6%	83.0%
Sacramento	85.2%	82.9%	80.5%	80.4%
Contra Costa	96.4%	92.9%	91.3%	93.0%
Fresno	65.4%	81.8%	77.6%	76.9%



Dashboard Data Sources

Metric, specific to county	Data Source
Penetration rates– individuals with at least 1 specialty mental health services visit.	County-specific data can be found: For children and youth data - http://www.dhcs.ca.gov/provgovpart/pos/Pages/September_2017_County_Aggregate_Reports.aspx For adults - http://www.dhcs.ca.gov/services/MH/Pages/2017_Adult_Population_County_Level_Aggregate_Reports.aspx For foster youth - http://www.dhcs.ca.gov/services/MH/Pages/September_2017_Foster_Care_County_Level_Aggregate_Reports.aspx
Hospital Inpatient days per unique beneficiary	
Hospital Inpatient admin days per unique beneficiary	
Mean time inpatient discharge and step down service, in days	
Percent of discharges by time between inpatient discharge and step down service	
Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year among Individuals Aged 12 or Older	SAMHSA https://www.samhsa.gov/data/population-data-nsduh/reports?tab=34
Needing But Not Receiving Treatment for Alcohol Use in the Past Year among Individuals Aged 12 or Older	SAMHSA https://www.samhsa.gov/data/population-data-nsduh/reports?tab=34
Mental and behavioral health diagnoses in emergency departments	Office of Statewide Health Planning and Development, ED discharge data, custom data extract and analysis by CalHPS. See attached spreadsheets additional detail.
Persons Served in CYBH Probation Programs; AOABH and CYBH Crisis Assessment Team call breakdown by evaluations and hospitalization	Orange County staff data
Use of psychotropic medication among youth in foster care, as a percent of foster youth	California Child Welfare Indicators Project, http://cssr.berkeley.edu/ucb_childwelfare/CDSS_5A.aspx
The number of incarcerated individuals receiving psychotropic medications (as a percent of average daily population)	BSCC JPS Online Query, http://calhps.com/reports/PolicyBrief_PsychotropicMedications_CalHPS.pdf
Unsheltered homeless population	Orange County Continuum of Care, 2017 Homeless Count & Survey Report. Prepared by Focus Strategies, July 2017

Methodological Notes

The metrics presented in this proposed dashboard include many mental health and behavioral health data that relate to access to care, population health, acuity, and delivery system efficiency. Although these metrics may not align exactly with MHSA services, these data points provide important context of the mental health care delivery system.

Some measures, like the penetration rates, are not conducive to assessing improvement because the rate is dependent on both the number of individuals accessing care as well as the total number of Medi-Cal recipients. Changes in either the numerator or denominator could be a result of multiple factors.

Other measures could be either an improvement or a worsening. For example, an increasing number of inpatient days in the short-term could reflect additional outreach and engagement whereas over the long-term could suggest a service delivery system that is not optimally efficient at serving individuals in out-patient settings.

The data from Office of Statewide Health Planning and Development (OSHPD) reflect specific Clinical Classification Software codes that groups diagnoses. Due to small cell suppression, OHSPD could not share data from some counties in some years. Therefore, in order to ensure fair county comparisons over time, the graphs included above reflect only those diagnoses codes that had data for all ten counties for all five years. For additional detail as to which codes are included, please see the attached spreadsheets.