Alameda County Mental Health Services Act Stakeholder's Meeting
November 20, 2020 • 2:00 pm – 4:00 pm
TELECONFERENCE REMOTE MEETING

Meeting called to order by **Mariana Dailey (Chair)**

Present Representatives: Viveca Bradley (MH Advocate/MHAAC/AA Family Outreach), Annie Bailey, Jeff Caiola (Consumer/Berkeley Bipolar Support Group), Margot Dashiel (NAMI/African American Family Outreach Project/ East Bay Supportive Housing Collaborative), L.D. Louis (MHAB), Elaine Peng (MHACC), Liz Rebensdorf (NAMI East Bay/MHSAAC), Katy Polony (Abode/IHOT), Mark Walker (Swords to Plowshare), Shawn Walker-Smith (MH Advocate), Sarah Marxer (PEERS/Family Member), Terri Kennedy (ACBH), Terri Kennedy (ACBH)
Guests: Carly Rachocki (ACBH), Juliene Schrick (ACBH)

ITEM	*DISCUSSION*	*ACTION*
Welcome and Introductions (Mariana)	**Mariana** reviewed conference call etiquette tips, and led a brief check-in with the group utilizing the Community Agreements and MHSA-SG Design Team Alliance (DTA) model to identify the desired atmosphere for the meeting and strategies to ensure members thrive and deal with conflict, and asked the group: **Mariana** stated that the meeting structure would focus on 2 of the MHSA-SG meeting structure elements: • Relationship Building, Leadership & Advocacy • Program Planning & Development • Administration & Operations	
Yellowfin Dashboard & Provider Incentives Presentation (Juliene S. and Carly R.)	**Carly** reviewed the presentation agenda: • FSP Overview – FSP is the highest MHSA beneficiary and serve Alameda County residents with the highest level of needs and typically on Medi-Cal. Their goal is to work on the recovery process. The Adult, Older Adult, and TAY models use the ACT model. FSPs consist of multidisciplinary teams featuring clinicians, peers, nurses, employment specialists, SUD, family advocates, housing specialists, and psychologists. Staff member work with every client and use a team-based approach. The client to staff ratio is 10:1 **Questions/Comments:** • **Liz** – Asked, when you said ratio is 10:1-clarify? **Answer:** Adult teams have 100-150 clients. For every 10 clients there's 1 staff member (except for TAY it's 8:1 ratio). • **Katy** -- Asked, what are expectations of FSPs? **Answer:** Respond really quickly and go out that day or day after to engage them. Clients seen multiple times a week or every day unless they're transitioning to lower level of care. The goal is to promote meaningful life in community and be successful and maintain safety like reducing hospitalizations and jail. • **Jeff --** Asked, around intake- do you have to be in the system already or what happens if it's your first time, criteria? **Answer:** Typically, people are folks who have	

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	been in the system who are usually known and high utilizers. • **Katy** – Asked, Do the FSPs have the capacity to provide these services? I've heard they have to do MediCal billing, is that a state or federal requirement? **Answer:** They clients are usually stabilized towards the end where the FSP intensity of services can be decreased. The ACT model is a specific recipe of tools and there's different methods they use to triage who and how they get services. Every morning begins with staff meetings to identify goals and they check-in with team members throughout the day. MediCal billing is a federal requirement, it's a county decision in terms of how FSPs are funded. MediCal billing is burdensome. • **Viveca**—Asked, who provides outreach in regards to many who have serious SMI on the street and is there an outreach project for them? **Answer:** In the current models FSPs don't do outreach for new clients. County ACCESS assigns clients to FSPS. Other systems support outreach like the crisis services division on top of Mobile crisis programs and familiar faces (which focused on homeless with SMI) and Health Care for the Homeless through office of the Health Care Services Agency Director • **Viveca** -- What's the handoff? Is there a system to hand them off to an FSP? **Julienne** reviewed the incentive structure and dashboard: • During FY 2017/18, ACBH piloted an incentive program to move towards a "value-based payment system" and not "fee for service" program. This means we focus on how well people are recovering versus time spent with the client. Incentivizing FSPs to improve the type of partners they have and how well the whole program is succeeding as opposed to counting widgets. Depending on metric of success FSPs can be incentivized based off the percent of people and their quality of care. This is on top of the usual budget for the program. • FSPs enter their data into the electronic health records. Additional records are pulled from alternative source such as Anthem Blue Cross exams, Sheriff, etc. This data is pushed into a warehouse and a Data Services firm cleans the data which is then pushed into the Yellowfin system to display. **<u>Questions/Comments:</u>** • **Liz** – Asked, how much is the incentive and is it substantial on the program? I'm guessing they could hire a new clinician if they hit all 4-performance metrics. • ***S*arah** -- Sometimes these incentives will make agencies serve people more likely to succeed. What	

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	are protections against that? **Answer**: It is a long, arduous process of developing this. It took years to formulate. There is a policy workgroup that goes through a major vetting process. • **Liz** -- How does this data collection tie into HMIS, do they talk? **Answer:** We do have HMIS data in our website not reflected in this dashboard but we do cross reference with FSP consumers. They get a report monthly to show who is on the HMIS by name so they can correct if necessary to increase their chance of getting permanent supportive housing • **Sarah** -- What is an episode is this enrollment? **Answer:** An opening to a team. It can be duplicated. You can have a person who is on one FSP & transition to another and have 2 episodes • **Katy** -- Depending on the population the FSP is dealing with would make it more difficult to connect with my them like the homeless population? How is an FSPs success determined? What's the experience of someone going into an FSP? **Answer:** Many of the people are disconnected and lack supports in their life. Many might be homeless similar with CJI FSP. Lots of overlap even though we have specializations. We use housing first model. It's hard to do in Bay Area. After, we help them be safe in community (medical providers, psychiatric prescribers if they choose to-voluntary), wrap supports around them to maintain housing. Once safety foundation is developed they focus on activities that bring them meaning. • **Liz** -- What is the commitment of the FSP when the client is not successful on their recovery? **Answer:** There is no time limit. Every situation is unique. Some have been in since FSPs started (not ideal but that's where they're at). FSPs are committed and usually there is a reason if that ends • **Sarah** -- Who has access? **Answer:** ACBH staff. What you see depends on what your position is because it is PHI. We do allow some CBOs to apply to have access like FSP. That process is in flux and changing. • **Katy** – What is the relation of FSP to subacute. If someone goes into Subacute factory do they save their place? **Answer:** Yes • **Katy** -- What percent of people going into a subacute are an FSP? **Answer:** I don't know we'd have to look. There are many more service teams than FSP. Someone coming out subacute would be connected to a service team or FSP. I don't know about going in. No matter what the FSP stays with them. If they're in for more than 6 months they may close them. • **Liz** -- Did you say they would be presented with a service team or FSPS because I beg to differ. **Answer:** I said often.	

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	• **Viveca** – Do you have quality assurance data in the dashboard like complaints? **Answer:** No, we don't get data from QA on this dashboard. They focus on clinical documentation for Medical. Quality Management /QI partners with us on other reports for the FSP level. At our last QI committee, they presented on last quarter report on grievances and appeals. They have their own dashboard. The content is categorized differently but don't share content just categories. If an FSP client makes an appeal and it's appropriate for someone like me who works in operations than I may do that • **Liz** -- Where do you get the name yellowfin? **Answer:** it's a product. They created yellowfin and we bought it. • **Viveca --** is this source of information in two places? **Answer:** Yes, they have the same data because they're entering it. They don't have data from other sources like sheriff office • **Katy** -- Do we have an idea of the number of FSP they service a little under 1,000, what's the need and what's the goal? **Answer:** You summed it up. Given financial situation it won't get broader. • **Margot** -- I'm interested in the employment function. How does this work and do we have data on the outcomes? **Answer:** All teams have the employment specialist and the data is in the second dashboard. An intake form asks if they employed, where, and do they have a goal to be employed. It's updated periodically. For FY19/20 at intake 28% enrolled in an FSP had an employment goal and this percent hasn't changed. At intake less Than 10 were employed. And most employment settings were supportive. They count volunteering as employed. **Carly reviewed ways the** Stakeholders can be involved such as promoting community change. • Due to HIPPA privacy concerns user testing is limited to internal staff and the public cannot access the dashboard due to privileged medical information. **<u>Questions/Comments:</u>** • **What type of data will be visible on the dashboard?** • What actions do you hope to inspire? We will continue using the MHSA plan to update the FSP section. Incentive data is in overall. It's accessible throughout the year to the public. • *How can stakeholder shape the design? User testing?*	
MHSA-SG Administrative	**Mariana** announced 2 new members from Ohlone College for the TAY membership: Carissa Samuel, Co-Chair of the Student	• **Mariana** will conduct a welcome orientation

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Updates/Membership and Announcements (Mariana) **Stakeholder** Announcements (Open)	Advisory Committee & VP of the Wellness Program and Yona, Student Ambassador for Ohlone Student Health Center, Student Government rep, and Graphic Designer for CovEd. **Mariana** reviewed recent legislative updates. **Liz** mentioned CAMPHRO will spearhead the peer certification trainings and not PEERS or other peer groups. **Sarah** provided information for a new resource. The Asian American Recovery Services provides SUD support in South County and are new to the system. **Liz** sways NAMI will continue to have general meetings which are posted on their website. Next meeting will be held in February 2021.	for the new members on 12/16/20. • ***Mariana*** will forward the Asian American Recovery Services brochure from Sarah to PEI and the Stakeholders.
Wrap-Up/Summary (Mariana)	**Stakeholder members** will be invited to support future planning efforts. **The group identified future meeting topics**: • Need to review MHSA-SG application questions	

Next Stakeholder meeting: Friday, December 18, 2020 from 2-4 p.m. LOCATION: GoToMeeting webinar